

C. H. PATTERSON

**COUNSELING AND PSYCHOTHERAPY:
THEORY AND PRACTICE**

132 P31c

67-13288

Patterson

Counseling and psychotherapy:
theory and practice



kansas city



public library

kansas city, missouri

Books will be issued only
on presentation of library card.

Please report lost cards and
change of residence promptly.

Card holders are responsible for
all books, records, films, pictures
or other library materials
checked out on their cards.

[illegible]

C. H. PATTERSON

University of Illinois

**COUNSELING
AND PSYCHOTHERAPY:
THEORY AND PRACTICE**

*Harper & Row, Publishers
New York, Evanston, and London*



COUNSELING AND PSYCHOTHERAPY: THEORY AND PRACTICE

Copyright © 1959 by C. H. Patterson

Printed in the United States of America

book are reserved. No part of the book may be used or reproduced
whatsoever without written permission except in the case of brief
l in critical articles and reviews. For information address
shers, Incorporated, 49 East 33rd Street, New York 16, N.Y.

G-O

Congress catalog card number: 59-9632

Contents

Preface

Part I Introduction

1. Counseling and Psychotherapy 3
2. Training in Counseling and Psychotherapy 13

Part II Background for Counseling and Psychotherapy

3. Ethics and Counselor Needs 31
4. Values and Psychotherapy 53
5. Cultural Factors and Psychotherapy 78

Part III The Therapeutic Relationship

6. Two Approaches to Human Relations 111
7. A Systematic View of Counseling and Psychotherapy 136
8. Implementing the Point of View 159
9. Transference and Countertransference 190
10. Diagnosis and Evaluation 219

Part IV Some Questions

11. Is Depth Psychology Necessary? 253
12. Psychotherapy: Art or Science? 279
13. Common Elements in Psychotherapy: Essence or Placebo? 295

Index of Names 313

Index of Subjects 320

KANSAS CITY (MO.) PUBLIC LIBRARY
6713257

Preface

Counseling individuals with general personal, social, or emotional problems is the concern of this book. Such counseling is sometimes called personal adjustment counseling or therapeutic counseling. It is not basically different from psychotherapy.

The selection of a text for an advanced course in counseling or psychotherapy presents a problem, whether this course is didactic in nature, a prepracticum, or a practicum. There are any number of books in the field of psychotherapy which would be useful to the student. But none of them meets the requirements of a text, that is, that it is comprehensive, dealing systematically with problems and issues significant to the student as he prepares for, or begins, actual counseling experience with clients. Some instructors may feel no need for a text at this level, preferring to have the student read in a number of sources. Still, there are aspects of counseling and psychotherapy that have not been dealt with in a manner and form accessible and useful to the student.

This book is an attempt to supply this need. The fact that it adopts a systematic point of view, namely an approach based upon phenomenological psychology and client-centered therapy, may of course deter some instructors of another persuasion from its use. These instructors may prefer a text based on another approach,

such as that of the Pepinskys.¹ Even for these instructors, however, Part II should be useful. The chapters on ethics and values in therapy, and the socio-cultural background of psychotherapy contain materials not found, to the writer's knowledge, in any other textbook in counseling or psychotherapy.

Belief in the desirability of a systematic approach to counseling is a bias of the author, though one which is shared by many others. The acceptance of this belief requires that a choice be made of a particular system. The Pepinskys recognize five systematic approaches to counseling. They designate these as the *trait-and-factor-centered approach*, the *communications*, the *self-theory*, the *psychoanalytic*, and the *neobehavioral* approaches. In our opinion, the first two do not represent approaches which are general enough or distinct enough to warrant the designation of being systematic. The last, the neobehavioral approach—in spite of the efforts of the Pepinskys, of Shoben, of Dollard and Miller, and of others—does not appear to have developed as yet to the stage of a systematic approach. The Pepinskys seem to recognize this when they say that “neobehaviorism is a movement in counseling which has seemed to hold promise for the experimentalist and the clinician in attempting to explain the what, how and why of client behavior. Between that promise and its fulfillment, however, lies a great region of doubt.”²

The actual choice seems to be between psychoanalysis and self-theory, or, as it is more generally known, the client-centered approach. The author has chosen the latter. This has not been on negative grounds, such as the complexity and varieties of the psychoanalytic approach, or the closed shop unionism of the analysts. This choice has been based rather on the belief that the client-centered approach is more generally applicable and effective than the psychoanalytic approach, and on the conviction that the

¹ H. B. Pepinsky and P. N. Pepinsky, *Counseling theory and practice*. New York: Ronald, 1954.

² *Ibid.*, p. 60.

client-centered approach contains, in their simplest and most basic form, the necessary and sufficient conditions for psychotherapeutic change.³

There are undoubtedly some who disagree with the adoption of a single point of view in the training of counselors, and who would contend that the student should be exposed to several different approaches. However, it seems to the author that no instructor can present differing points of view with equal effectiveness, since his own interests and preferences—and bias—affect his teaching. Students, therefore, are captive to the approach favored by the instructor. This is true whether the instructor openly espouses one approach, or proposes to be neutral. Since this is the case, I prefer the former. Students are clearly aware of the instructor's preference. Other approaches are of course dealt with, and students are encouraged to read discussions of other points of view. But essentially they have little if any choice in the face of the influence of the instructor. I can see no alternative to this. Students who are unable to accept the client-centered approach—and they are actually few—and those who want to be exposed to another approach, may seek other sources for instruction.

The client-centered approach includes two aspects—a philosophy of human relations and a theory of human behavior. The philosophy is one which stresses the value of the individual, of his development as a person and a self in a group of other selves. The theory of human behavior is a phenomenological field theory. The application of this theory to psychotherapy has been made by a number of writers. To the present writer the theory is applicable beyond psychotherapy. Psychotherapy is of a piece with all behavior; and a theory of psychotherapy must also be a theory of learning, of personality, and of behavior in general. The two aspects of client-centered therapy, the philosophy and the theory of human behavior, are woven together in the presentation. The

³ C. R. Rogers, The necessary and sufficient conditions of therapeutic personality change. *J. consult. psychol.*, 1957, 21:95-103.

point of view developed here has many similarities to the existentialist position as presented by May,⁴ which is also based on phenomenology. There are some differences however, one being the acceptance of depth psychology by the existentialists. May's work was not available when this book was written, so no discussion of his position is included.

This, then, is the bias of the author, and influences the discussion of theory and practice which follows. It is a bias which seems to be shared by an increasing group of instructors, and it is hoped that the book will be found to be useful to many other teachers of courses in counseling and psychotherapy.

This is not a "how-to-do-it book." The emphasis is upon the theory and philosophy of an approach to counseling rather than upon techniques. The latter are dealt with extensively in many other books. Although the practical problems facing the counselor as he begins to work with clients will be discussed, the counseling process will not be considered in detail. The counseling process is integrated into the ethical and value orientation of our culture, as well as into a systematic psychological approach to human behavior.

A word needs to be said about terminology. There is no agreement regarding the distinction between counseling and psychotherapy.⁵ They are frequently used interchangeably; they are so used in this book. There is no difference in the basic principles, assumptions, or goals of counseling and psychotherapy, though there may be differences in technique. Differences in technique relate to some extent to the nature of the problem. Thus vocational, educational, or marital problems may involve lack of information, and information giving may be an appropriate technique. Counseling individuals with general personal, social, or emotional problems, often called personal counseling, or therapeutic counseling, is not basically different from psychotherapy.

As the terms counseling and psychotherapy are used inter-

⁴ R. May, H. F. Ellenberger, & E. Angel (Eds.), *Existence: a new dimension in psychiatry and psychology*. New York: Basic Books, 1958.

⁵ See Chapter 1 for a discussion of this problem.

changeably, so are the terms client and patient. The term client is preferred, to avoid the connotation of physical illness or disease, but medical therapists and psychoanalysts use the term patient, so it is used here in such contexts.

The writing of this book grew out of the author's experience in teaching a practicum course in counseling. While a major purpose of the practicum is providing the student with supervised practice in counseling, there are, in the writer's opinion, at least two other purposes, which did not seem to be met adequately by existing materials. The first is the development in students of a professional attitude. This includes the acquisition of a code of ethics, and a recognition of the reasonable expectations from and limitations of counseling and psychotherapy. The second is the development of a systematic approach to counseling and psychotherapy. While there may be some who feel that the student should be encouraged to try or apply various approaches in his beginning counseling, the writer believes that if the student is to be able to integrate his experiences he needs a theoretical or systematic framework as a basis. One such framework is suggested in this book.

Rather than waiting until the student is embarked upon practice (unless there is a preliminary didactic period as part of the practicum) it may be desirable that he be introduced to these aspects of professional development in the preceding advanced or pre-practicum courses. This book therefore should be useful in such advanced courses, whether or not they are followed by a practicum. On the other hand, counselors and therapists already in the field may find it useful in the development of a systematic framework for their practice.

Because there is some discussion but no general agreement regarding the background for and the nature of training, particularly practicum training, in counseling and psychotherapy, this problem is considered in Part I. While perhaps more pertinent to the instructor, it gives the student a picture of the background and stages of preparation for counseling, including the specific objec-

tives and values of the practicum course. Part II deals with ethics and values in counseling, and the social background for counseling and psychotherapy. Part III develops a systematic approach to psychotherapeutic practice, attempting to base practice upon a general approach to human behavior and human relationships. Finally, Part IV discusses some of the significant questions in counseling and psychotherapy.

The author is indebted to Gardner Murphy, the editor of the series in which this book appears, for raising questions which led to the clarification of his thinking on a number of points and thus, it is hoped, improved the exposition. The editor is of course not to be held responsible for any of the ideas or opinions expressed. My debt to the many writers in the field, particularly to Carl Rogers and other client-centered therapists, is abundantly clear in the text and references. The material has been improved by its use with several groups of students in a counseling practicum course. This use has also made the writer aware of its incompleteness and shortcomings, which have required amplification in teaching.

Parts of Chapter 4 appeared as an article in the *Journal of Counseling Psychology*, and the author is indebted to Dr. C. G. Wrenn, the editor, for permission to use the material here. Chapter 6 was first published in the *American Journal of Psychotherapy*, and is included here, with some minor changes, by permission of Dr. Emil A. Gutheil.

Several typists contributed to the book, and again Mrs. Julia Snyder rendered invaluable service in supervision and proofing of the typing. As in any work of this nature, the author's family contributes much, including the acceptance of a certain amount of neglect. The book should therefore be dedicated to my wife, Frances, and our children, Joe, Penny, Jenifer, Christopher, Tom, and Mary Victory, the last of whom arrived coincidentally as the manuscript was completed.

C. H. PATTERSON

PART I

.....

INTRODUCTION

CHAPTER 1

Counseling and Psychotherapy

The terms counseling and psychotherapy are both widely used, often more or less interchangeably. While there seems to be general agreement that they are not exactly synonymous, there appears to be no general agreement regarding the differences between them. Guidance is another term which is sometimes used interchangeably with counseling. While we do not hope to resolve the confusion surrounding the use of these terms, it seems desirable to discuss the question and thus orient the reader to the point of view and place of this book in the field.

We can begin by distinguishing between guidance and counseling. The term guidance has long been used in the field of personnel services to students below the college level. It is generally used to designate the whole area of individual and group work with students. It thus covers the field known as student personnel work at the college level. Counseling is only one of the functions of a student personnel program (22). It would seem preferable to use the same terminology both at the secondary school and the college levels. Furthermore, the word guidance has a connotation which is somewhat inconsistent with the current client-centered orientation of student personnel work. It is suggested that it should be

abandoned, and the term student personnel work substituted for it. The movement to do this was begun in 1946 with the first edition of Warter's book (21). But almost without exception, texts on student personnel work at the high school and elementary school levels still cling to the term guidance in the title.

The distinction between counseling and psychotherapy is not as easily drawn. Members of the Ann Arbor Conference on the training of psychological counselors were unable to agree on the distinction, though all felt that there was one. They did apparently feel that counseling and psychotherapy lie on a continuum. This concept has been used by a number of writers. The members of the conference referred to felt that "counseling is concerned with the essentially normal individual," and "is seen as clinical treatment intended to prevent emotional difficulties or, more positively, to enable basically adequate people to move along the road toward an ideal level of adequacy" (8, p. 9).

The Committee on Definition of the Division of Counseling Psychology of the American Psychological Association has struggled with this problem. This committee points out that counseling was early identified with psychometrics and vocational guidance but that it became apparent that "earlier concepts of counseling as restricted to the matching of individual abilities and interests with occupational requirements needed to be modified," as a result of the recognition of the importance of personality and emotional development in vocational choice. Psychotherapy, also, was being modified and applied in "everyday counseling situations" (1).

But "Because it aims to contribute to the personal development of a great variety of people counseling psychology does not concern itself only with the more extreme problems presented by individuals who are in need of emergency treatment. In other words, counseling psychology does not place special emphasis upon the development of tools and techniques necessary for intensive psychotherapy with individuals whose emotional growth has been severely distorted or stunted. . . . The counseling psycholo-

gist wants to help individuals toward overcoming obstacles to their personal growth, wherever these may be encountered, and toward achieving optimum development of their personal resources" (1).

This definition appears to be couched in terms of severity of disturbance. Counseling concentrates on helping the essentially normal individual remove obstacles to his optimum development, rather than being concerned with "the emergency treatment of psychological disasters." But there is also another element, and that is the fact that these obstacles are usually of an environmental or situational nature rather than a personality disturbance. The use of such modifying terms as educational, vocational, marital, etc., with counseling is also an indication of this factor. Counseling may thus be considered to be concerned with helping the client cope with reality problems rather than with internal personality conflicts.

Bordin accepts a quantitative rather than a qualitative distinction. He states that "The counseling relationship is characterized by much less intensity of emotional expression and relatively more emphasis upon cognitive and rational factors than is the relationship in psychotherapy. . . . His [the client's] difficulties are certainly less severe, with, therefore, less distortion of reality than the client who requires psychotherapy" (3, pp. 15, 60). Mowrer also appears to agree with this distinction, defining counseling as "the process of giving professional or expert help to persons suffering from fully-conscious conflicts which are accompanied by so-called normal anxiety" (12, p. 23).

Super (20), however, points out that counseling cannot be limited to the normal person. It also applies to the handicapped, the abnormal, or the maladjusted person. But he agrees that it deals "with the normalities even of abnormal persons, with locating and developing personal and social resources and adaptive tendencies so that the individual can be assisted in making more effective use of them."

The fact that counseling does include working with abnormal clients—including severely mentally disturbed patients—on their educational, vocational, occupational, marital, and other special problems suggests that supplementing a distinction between counseling and psychotherapy in terms of the type of client dealt with is a difference in focus. Sanderson (17) discusses this difference between the counselor and the psychotherapist. The counselor focuses upon a particular area such as the vocational area, in which the client is having difficulty; while the psychotherapist concerns himself with the total personality structure. It is true that the client is always a total person, and can only be dealt with as such, so that the counselor does work with the total personality. Yet it is possible to emphasize, or to focus upon, a particular problem area. Thus, it is possible to counsel with severely emotionally disturbed clients about their vocational rehabilitation without becoming involved with attempts to treat the emotional disturbance (14).

However, the counselor may deal not only with specific situational problems or problem areas, but with problems of personal, social, and emotional adjustment. Here it is much more difficult to apply the concept of focus. It is in this area that it does not seem to be possible to draw a line between counseling and psychotherapy. Mowrer's distinction is one which is difficult to apply. It is not easy to distinguish between normal and neurotic anxiety, between conscious and unconscious conflicts. Both may be present. In this case, however, the distinction in terms of severity of disturbance determines whether one is considered to be doing counseling or psychotherapy, with no clear dividing line being possible.

Counseling, then, may be thought of in terms of focus upon particular problem areas, and the adjectives commonly applied to counseling indicate these areas, e.g., educational, vocational, rehabilitation, marital, etc. It therefore seems to be desirable to have a term to designate counseling in the area of personal adjustment problems. Personal adjustment counseling, or personal counseling,

has frequently been used, as has the term therapeutic counseling (16). Possibly the latter is tautological since all counseling should be therapeutic. It does, however, serve to indicate the nature of the counseling, and to distinguish it from other types of counseling.

The question arises as to whether the techniques of counseling and psychotherapy differ. Mowrer writes: "I think it is fair to suppose that the techniques of counseling and psychotherapy are quite different." He cites counseling as an attempt "to give . . . information, guidance as to resources, suggestions, perhaps advice and directives" (12, p. 24). Most counselors would probably not accept some of these as techniques of counseling, but we agree that counseling *techniques* may differ from psychotherapeutic *techniques*. In so far as the client faces a reality problem, clearly on the conscious level, the techniques of counseling may vary from those of psychotherapy. Where information is lacking, it may be given. The discussion can be on a more logical, rational level than is usually the case in psychotherapy. In the opinion of the writer, however, techniques of *therapeutic* counseling are no different from those of psychotherapy.

The distinction between therapeutic counseling and other types of counseling must be kept in mind in any discussion of counseling practice. Failure to do so leads to unnecessary conflicts over techniques of counseling. Many texts in counseling fail to distinguish between the two, with resulting confusion when dealing with counseling techniques. Often authors reject client-centered counseling because they feel its techniques cannot be applied in educational-vocational counseling. However, the counselor need be no less client-centered in educational-vocational counseling than in therapeutic counseling, even though the techniques he uses may differ. The client-centered approach to counseling is essentially an attitude, not a group of techniques. The client-centered attitude is applicable in all types of counseling, though it may be implemented by differing techniques in differing situations. The author has dealt with the application of the client-centered approach to

vocational counseling in another publication (14, Chs. 7-11). This book is concerned with therapeutic counseling and its techniques.

The process of helping individuals may be conceived as varying on a continuum. At one end help may be given in the form of simple information. An information center with its specialists is an example. Further along the continuum more technical information may be given—faculty “advising” with regard to the choice of an educational program is an example. Then counseling towards an educational-vocational or occupational choice may be further along the continuum, followed by premarital or marital counseling. Therapeutic counseling, or counseling in the area of general personal adjustment problems, would follow, and at the extreme end would be intensive psychotherapy or psychoanalysis. The concepts of focus and of severity of the problem or disturbance are combined in this continuum. Where there is a focus upon a particular area, the problem is usually a reality problem in a more or less normal personality.

The present concept of the relation of counseling and psychotherapy may be compared with that reached by a Commission in Counseling and Guidance of the New York Academy of Sciences, and formulated by Perry (15). This formulation includes the concepts of intensity of disturbance and focus, as does the one developed here. However, while Perry would limit psychotherapy to severe intrapersonal conflicts, this would not be a restriction acceptable to the author—nor, it is believed, would it be accepted by most psychotherapists, and certainly not by those of the Sullivanian school. Secondly, Perry classifies personal counseling or psychological counseling at the counseling rather than the psychotherapy end of his continuum. He conceives it as being concerned with social problems, or social roles, differing from educational, vocational, or marital problems mainly in terms of involving several roles rather than being limited to one. He does, however, acknowledge that these terms are sometimes “misused” to refer to

psychotherapy. Thus, although he speaks of a continuum, there appears to be no place on it for therapeutic counseling as defined here.

Possibly there should be no distinction made between therapeutic counseling and psychotherapy. The distinction in terms of severity is not a sufficient one, since there is no clear dividing point on the continuum where counseling ends and psychotherapy begins. Moreover, since there is no difference in techniques, a distinction is probably not justified. Nevertheless, there are perhaps practical reasons for making a distinction. Although no sharp line can be drawn in terms of severity, there are many persons needing assistance who can be helped by individuals who are not psychiatrists or trained to the doctoral level in psychology. Possibly such persons should be designated as counselors rather than psychotherapists. There is also the practical problem of avoiding disputes with psychiatry and the medical profession. For this reason, many prefer to use the term counselor even to designate those who are trained to the doctoral level and who are working with severely disturbed individuals. The avoidance of the term psychotherapy may reduce conflict. This raises the question of who should do psychotherapy.

The question as to who should practice psychotherapy has had considerable discussion during the past several years (2, 4, 6, 9, 11, 13, 18, 19). This is not the place to enter into a review or consideration of the problems involved. Anyone engaged in therapeutic counseling should be aware of the issues, however, and for this reason the topic is introduced here. For a recent discussion the student is referred to the book edited by Krout (10).

Fundamentally, the question reduces to whether a medical degree is essential for the practice of psychotherapy. The medical profession, including official psychiatry, claims that it is. Some would allow nonmedical therapists to practice under the supervision of a psychiatrist. Since there are competent therapists with varying backgrounds, it can hardly be maintained that any particu-

lar background is essential. This argument also applies to the claims that medical training is necessary. Since there are accepted, respected therapists of acknowledged competence practicing without a medical background, it would appear that it is impossible to hold that medical training is necessary for the practice of psychotherapy. Hollingshead and Redlich, the latter a psychiatrist, state the question nicely. "Why should a nonmedical problem, such as emotional reëducation in work and family life, remain the domain preëmpted by the medical profession?" (7, p. 378). They feel that "As long as these counselors, and with some courage we might call them therapists, are well trained and do not dabble in fields beyond their training, there should be no meaningful objection to such a venture."

Freud himself (5), though medically trained, did not believe that such training was necessary. In fact, he felt that medical training might be a handicap to the practice of psychoanalysis. There are a number of outstanding psychoanalysts who have not had medical training. Nevertheless, since 1938 it has not been possible to obtain training for practice in psychoanalysis without having the M.D. degree.

There is a need for counseling and psychotherapy which cannot be met by medically trained therapists, and which does not require medical training in those who can meet this need. This need is found in students in our public and private schools and colleges, in our public and private community clinics and agencies, in industry, and in our churches. Not only can the needs of many of these people be met by nonmedically trained counselors and therapists, but also by those not trained to the doctoral degree in psychology. In fact, most of the services being rendered in the field are probably being given by counselors and therapists who have had little if any intensive preparation or supervised practicum training. Counselors in these institutions and agencies are being called upon to practice psychotherapy, either because, in some cases, there are no other treatment facilities available, or because there are many

troubled people who do not require the services of a psychiatrist or psychoanalyst, or even a psychologist with a Ph.D. We cannot send everyone with personal-social-emotional problems to psychiatric clinics, nor should we.

With this demand for services, rather than retreating behind the wall of denying training in counseling and psychotherapy to sub-doctoral students—who will in many cases go out and practice therapy anyway—it behooves us to give as adequate training as possible. And this is more than a temporary compromise, because, as suggested in the next chapter, students can be adequately trained as counselors and therapists without necessarily completing a doctoral program in psychology.

There is, then, a place for therapeutic counseling by those who do not have the training of a psychologist, psychiatrist, psychoanalyst, or the long training that is felt by some to be required by anyone calling himself a psychotherapist. There seems to be need for a term to designate those who do such therapeutic counseling. The most appropriate term appears to be counselor. Although there may be a distinction between counseling and psychotherapy in terms of the severity of personality disturbances dealt with by counselors and psychotherapists, there is no difference in the methods or techniques used. Therefore, in discussing attitudes, methods, and techniques in this book, the terms counseling and psychotherapy are used interchangeably.

REFERENCES

1. American Psychological Association, Division of Counseling Psychology, Committee on Definition. Counseling psychology as a specialty. *Amer. Psychologist*, 1956, 11:282-285.
2. Ausubel, D. P. Relationships between psychology and psychiatry: the hidden issues. *Amer. Psychologist*, 1956, 11:99-104.
3. Bordin, E. S. *Psychological counseling*. New York: Appleton-Century-Crofts, 1955.
4. Brody, E. B. Interprofessional relations of psychologists and psychiatrists are human too, only more so. *Amer. Psychologist*, 1956, 11:105-111.
5. Freud, S. *The problem of lay analysis*. New York: Brentanos, 1927.

6. Galdston, I. The problem of medical and lay psychotherapy: the medical view. *Amer. J. Psychother.*, 1950, 4:419-431.
7. Hollingshead, A. B., & Redlich, F. C. *Social class and mental illness*. New York: Wiley, 1958.
8. Institute for Human Adjustment. *Training of psychological counselors*. Ann Arbor: University of Michigan Press, 1950.
9. Jenkins, R. L. Understanding psychiatrists. *Amer. Psychologist*, 1954, 9:617-620.
10. Krout, M. H. (Ed.) *Psychology, psychiatry, and the public interest*. Minneapolis: University of Minnesota Press, 1956.
11. Menninger, K. Psychology and psychiatry. *Amer. Psychologist*, 1947, 2:139-140.
12. Mowrer, O. H. Anxiety theory as a basis for distinguishing between counseling and psychotherapy. In R. F. Berdie (Ed.), *Concepts and programs of counseling*. Minnesota Studies in Student Personnel Work, No. 1. Minneapolis: University of Minnesota Press, 1951. Pp. 7-26.
13. Oberndorf, C. P., et al. Discussion (Symposium on "The problem of medical and lay psychotherapy"). *Amer. J. Psychother.*, 1950, 4:442-456.
14. Patterson, C. H. *Counseling the emotionally disturbed*. New York: Harper, 1958.
15. Perry, W. G., Jr. The findings of the commission in counseling and guidance. (On the relation of psychotherapy to counseling.) In R. W. Miner (Ed.), *Psychotherapy and counseling*. New York: New York Academy of Sciences, 1955.
16. Porter, E. H., Jr. *An introduction to therapeutic counseling*. Boston: Houghton Mifflin, 1950.
17. Sanderson, H. *Basic concepts in vocational guidance*. New York: McGraw-Hill, 1954.
18. Sanford, F. H. Relations with psychiatry. *Amer. Psychologist*, 1953, 8:169-173.
19. Sanford, F. H. Psychology, psychiatry, and legislation in New York. *Amer. Psychologist*, 1954, 9:160-164.
20. Super, D. E. Transition: from vocational guidance to counseling psychology. *J. counsel. Psychol.*, 1955, 2:3-9.
21. Warters, Jane. *High school personnel work today*. (2nd ed.) New York: McGraw-Hill, 1956.
22. Wrenn, C. G. *Student personnel work in college*. New York: Ronald, 1951.

CHAPTER 2

Training in Counseling and Psychotherapy

"Psychotherapy is a process involving interpersonal relationships between a therapist and one or more patients or clients by which the former employs psychological methods based on systematic knowledge of the human personality in attempting to improve the mental health of the latter" (1). This definition of psychotherapy, or counseling, would be accepted, at least as a first approximation, by most psychologists. But when one tries to find what is considered to be adequate preparation for counseling and psychotherapy, there is less agreement. The amount and kind of "systematic knowledge of the human personality" considered as necessary or desirable vary.

BACKGROUND FOR PSYCHOTHERAPY

There are two rather opposed points of view regarding the preparation necessary for the practice of psychotherapy. On the one hand there is the position that psychotherapy, even under supervision, should not be engaged in until late in the training of doctoral students, or even should be postponed to the post-doctoral period (15). The Committee on Training in Clinical Psychology of the American Psychological Association (1) proposed that lecture and discussion courses not begin until the second year of

graduate training, and stated that "Really advanced training in therapy is, with few exceptions, a problem of the post-doctoral period . . ." Most recommended training programs place actual practice in psychotherapy rather late in the curriculum (2, 5). The curriculum outlined by Brody and Grey (6) places it in the third year of graduate training.

Outlines of such training programs list numerous graduate courses, following appropriate undergraduate preparation. These courses include a "core curriculum" (4) consisting of courses in "scientific method and psychological research, historical trends in psychology, statistics, normal and abnormal modes of adjustment, personality organization, individual differences and their measurement, developmental psychology," as well as techniques courses. Another report (3) lists as educational prerequisites to initial field work, classroom instruction in the following areas: personality organization and development, knowledge of social environment, appraisal of the individual, case seminars, and laboratory work in testing and interviewing. For an interview relationship with a client without major responsibility for the client, additional work in appraising the individual is listed, together with counseling theory and professional orientation. Finally, for carrying major responsibility for a client, additional work in counseling theory and techniques is a prerequisite.

The Pepinskys (14, p. 151) feel that "a knowledge of a range of empirical-experimental literature, extending to studies in animal learning and cultural anthropology, can help the counselor to understand client behavior." Rollo May (9, p. 176) concurs in the importance of cultural anthropology, and also lists literature, art, mythology, ethics, religion, and philosophy, in addition to the basic study of personality theory; and abnormal, social, and child psychology, as well as neurology.

Nevertheless, one must not forget that it is the personality of the therapist which appears to be basic in counseling and psychotherapy. Academic training or information has little if any influ-

ence on this personality. Rogers (18) states that special intellectual professional knowledge is not required of the therapist. It is "qualities of experience, not intellectual information," which are important, and "if they are to be acquired, they must, in my opinion, be acquired through an experiential training—which may be, but usually is not, a part of professional training." The practicum itself, therefore, becomes important as a test of whether the student possesses, not the information, but the personality appropriate for functioning as a psychotherapist. Also, it is the only course in which he can develop or progress in achieving a therapeutic personality.

This consideration leads to the other point of view, that training in psychotherapy, including practical experience, should come early in the student's training. Rogers (16, p. 433) says that "the practice of therapy should be a part of the training experience from the earliest practicable moment." The National Vocational Guidance Association recommendation, while referring to vocational counseling, would appear to be equally applicable to psychotherapy. It states that "The introduction of supervised experience should be initiated as early in the course of preparation as the maturity and responsibility of the individual student allows (11, p. 15).

It is difficult, if not impossible, to establish any *necessary* prerequisites in terms of specific courses or even general areas of training. The fact that therapists who are recognized as competent have had training in widely different areas makes it impossible to declare that any particular type of preparation or background is necessary. Therapists have had backgrounds in medicine, anthropology, sociology, social work, theology, and other fields as well as in psychology. What these competent therapists have in common is an understanding of people. Often this is not acquired in formal training. There are other ways, possibly equally good, or better, of acquiring this understanding, besides through the study of psychology. Rogers (17, pp. 78-79) refers to "experiential

learning," as distinguished from cognitive learning, and suggests that it is this experiential learning rather than cognitive learning which is more important in training in therapy.

Nevertheless, for most students, some graduate academic background is desirable. It provides a more or less common minimum for entering into an understanding relationship with a client. Rogers (16, pp. 436-440) has indicated a desirable background for counselors. He includes a broad background of knowledge of the human being in a cultural setting, the ability to achieve empathy with others, the possession of a philosophy of life, and a knowledge of the dynamics of personality. He suggests some course areas which can contribute to this background. A wide variety of courses may contribute to an understanding of human beings and behavior, including anthropology, sociology, literature, and philosophy as well as psychology. Indeed, courses in these fields may be of more value than some psychology courses.

Since the basic requirement in counseling and psychotherapy is understanding people, a broad background of experience with people would be helpful. It is rare for the average individual, particularly if he is in his early twenties, to have been exposed to a very broad range of experience. There are those who suggest or recommend that some work experience be required prior to graduate study, presumably to assure some degree of maturity and a better or broader understanding of people.

It is possible, however, to acquire and develop considerable understanding of people vicariously. This, of course, is the assumption behind the requirement of courses in psychology. There are also other sources which are often more valuable in this respect than psychology textbooks. These include literature, from the classics to popular novels, biographies and autobiographies, personal experience histories, and literary case studies.

The author encourages his students to read, both for pleasure and profit, in these fields. In order to provide sources for such reading, a list of materials has been compiled. This selection,

made only on the basis of the personal background and reading of the author, is included here because it is felt that other instructors might find it of some use with their students.

READING LIST IN LITERATURE AND PERSONAL EXPERIENCE REPORTS

- Adams, H. *The education of Henry Adams*. Boston: Houghton Mifflin, 1935.
- Alper, Thelma G. An electric shock patient tells his story. *J. abnorm. soc. Psychol.*, 1948, 43:201-210.
- Analysand. Human limitations in analysis. *Int. J. soc. Psychiat.*, 1955, 1 (2):63-65.
- Anderson, S. *Winesburg, Ohio*. New York: Boni and Liveright, 1919.
- Anderson, S. *Tar*. New York: Boni and Liveright, 1926.
- Anonymous. An autobiography of a schizophrenic experience. *J. abnorm. soc. Psychol.*, 1955, 51:677-689.
- Balchin, N. *Mine own executioner*. Boston: Houghton Mifflin, 1946.
- Beers, C. *A mind that found itself: an autobiography*. New York: Doubleday, 1950.
- Bellamann, H. *Kings row*. New York: Simon and Schuster, 1940.
- Brand, Miller. *The outward room*. New York: Simon and Schuster, 1937.
- Brown, C. *Brainstorm*. New York: Rhinehart, 1944.
- Butler, S. *The way of all flesh*. New York: Modern Library, 1950.
- Caldwell, E. *Tobacco road*. New York: Scribner, 1932.
- Conrad, J. *The nigger of the Narcissus*. New York: Doubleday, Doran, 1921.
- Crane, S. *Twenty stories by Stephen Crane*. New York: Knopf, 1940.
- Cromwell, N. A. *Escape this life alive*. Boston: Bruce Humphries, 1955.
- Custance, J. Mental hospitals and mental treatment. *Int. J. soc. Psychiat.*, 1955, 1 (1):66-70.
- Dos Passos, J. *U.S.A.* New York: Modern Library, 1930.
- Dostoyevsky, F. M. *The brothers Karamazov*. New York: Modern Library, 1943.
- Dostoyevsky, F. M. *Crime and punishment*. New York: Modern Library, 1950.
- Evans, Jean. *Three men: an experiment in the biography of emotion*. New York: Knopf, 1954.
- Farrell, J. T. *Studs Lonigan*. New York: Vanguard Press, 1935.
- Faulkner, W. *Sanctuary*. New York: Random House, 1931.
- Fisher, V. *In tragic life. No villain need be. Passions spin the plot. We are betrayed.* (4 vols.) New York: Pocket Books, 1951-1953.
- Freeman, Lucy. *Fight against fears*. New York: Crown Publishers, 1951.

- Freeman, Lucy. *Before I kill more*. . . . New York: Crown Publishers, 1955.
- Galsworthy, J. *The Forsyte saga*. New York: Scribner, 1933.
- Gerber, I. J. *Man on a pendulum: a case history of an invert*. New American Press, 1956.
- Gide, A. *The counterfeiters*. New York: Modern Library, 1931.
- Green, J. *The closed garden*. New York: Harper, 1928.
- Hackett, P. *The cardboard giants*. New York: Putnam, 1952.
- Hardy, T. *Tess of the d'Urbervilles*. New York: Harper, 1920.
- Hillyer, J. *Reluctantly told*. New York: Macmillan, 1927.
- Horton, P. *Hart Crane*. New York: Norton, 1937.
- Howard, A. R. The patient speaks, *J. clin. Psychol.*, 1955, 11:381-385.
- Hull, Helen. *Through the house door*. New York: Coward-McCann, 1940.
- Huxley, A. *Point counterpoint*. New York: Doubleday, Doran, 1928.
- Ibsen, H. *A doll's house*. New York: Modern Library, 1935.
- Joyce, J. *A portrait of the artist as a young man*. New York: Modern Library, 1928.
- King, Marian. *The recovery of myself: a patient's experience in a hospital for mental illness*. New Haven: Yale University Press, 1931.
- Knight, J. *The story of my psychoanalysis*. New York: Pocket Books, 1952.
- Kramm, J. *The shriek*. New York: Random House, 1952.
- Krauch, E. *A mind restored*. New York: Putnam's Sons, 1937.
- Lawrence, D. H. *The rainbow*. New York: Modern Library, 1915.
- Leonard, W. E. *The locomotive god*. New York: Century, 1927.
- Lewis, S. *Main Street*. New York: Harcourt, Brace, 1921.
- Lewis, S. *Babbitt*. New York: Harcourt, Brace, 1922.
- Lindner, R. *The fifty-minute hour*. New York: Bantam Books, 1956.
- Maine, H. *If a man be mad*. New York: Doubleday, Doran, 1947.
- Mann, T. *The magic mountain*. New York: Knopf, 1941.
- Molnar, F. *Liliom*. New York: Boni and Liveright, 1921.
- Moore, W. L. *The mind in chains: the autobiography of a schizophrenic*. New York: Exposition Press, 1955.
- O'Neill, E. *Ah, wilderness!* New York: Random House, 1933.
- Rawlings, Marjorie K. *The yearling*. New York: Scribner, 1940.
- Rolvaag, O. E. *Giants in the earth*. New York: Harper, 1927.
- Santayana, G. *The last Puritan*. New York: Scribner, 1936.
- Seabrook, W. *Asylum*. New York: Harcourt, Brace, 1935.
- Sewell, L. G., Gillin, J., & LeBar, F. M. Through the patient's eyes: hospital patient attitudes. *Ment. Hyg.*, 1955, 39:284-292.
- Schnitzler, A. *Flight into darkness*. New York: Simon and Schuster, 1931.
- Shrodes, Caroline, Van Gundy, J., & Husband, R. W. (Eds.) *Psychology through literature; an anthology*. New York: Oxford University Press, 1943.

- Steffens, L. *Autobiography of Lincoln Steffens*. New York: Harcourt, Brace, 1931.
- Steinbeck, J. *The grapes of wrath*. New York: Viking, 1939.
- Tolstoy, L. *Anna Karenina*. London: Oxford University Press, 1918.
- Turgenev, I. *Fathers and sons*. New York: Dutton, 1922.
- Undset, Sigrid. *The longest years*. London: Capel, 1940.
- Ward, Mary. *The snake pit*. New York: Random House, 1946.
- White, R. W. *Lives in progress*. New York: Dryden Press, 1952.
- Wolfe, T. *Look homeward angel*. New York: Scribner, 1947. (Also Modern Library.)
- Wolfe, T. *Of time and the river*. New York: Scribner, 1944.
- Wolfe, T. *The web and the rock*. New York: Harper, 1939.
- Wolfe, T. *You can't go home again*. New York: Harper, 1940.
- Woodson, Marion M. *Behind the door of delusion, by "Inmate, Ward 8."* New York: Macmillan, 1932.
- Wright, R. *Native son*. New York: Modern Library, 1942.
- Wright, R. *Black boy*. New York: Harper, 1945.
- Wunsch, R. V. R., & Alber, Edna. *Thicker than water*. New York: Appleton, 1939.

DESIRABLE PERSONAL QUALITIES

Most would agree that the personal characteristics, or personality, of the therapist are important, and that those being trained in psychotherapy should be selected on the basis of such characteristics. There is little agreement, however, on just what these characteristics are, and no adequate means of assessing those upon which there is agreement.¹

Mowrer (12) uses the term "personal maturity" to refer to the important characteristic, but admits there is no trustworthy method for measuring it. He also emphasizes motivation, or interest in the process and goals of therapy. But "proficiency as a therapist calls for talents which at present lie beyond the scope of established tests or formal teaching methods" (12). Rogers expresses his opinion as follows: "If an individual is bright, sensitive, and desirous of doing psychotherapy, he is probably a suitable candidate for this field, in the present state of our ignorance" (17, p. 76).

¹ See chap. 3 of Patterson (13) for a discussion of this problem.

To some extent, candidates for practice in psychotherapy can be selected on the basis of performance in didactic courses where there is opportunity for their participation in discussions, reactions to recorded counseling interviews, and role-playing. But perhaps the practicum itself is the best place for the student to learn whether he can function adequately as a psychotherapist.

The place of personal therapy in training is not agreed upon. There are some who would require it, as the didactic or training analysis is a necessary part of training for the practice of psychoanalysis. Most would agree that personal therapy is desirable. It gives the student personal experience of the therapeutic process. It also is valuable in helping the student develop some understanding of himself, his motivations, needs, and problems. But personal therapy for counseling trainees should, as in the case of other clients, be on a voluntary basis.

Some feel that the instructor of the practicum can both teach and counsel with his students. However, if students obtain therapy elsewhere, it is still possible, by individual supervision of the student, to help him achieve some insights into his own needs as they affect his counseling of clients. Indeed, this is one of the objectives of a practicum course.

TECHNIQUES OF TRAINING

The training of psychotherapists employs a variety of techniques. There are, of course, didactic lecture and discussion courses in theories and methods of counseling and psychotherapy. These courses should introduce the student to the varying systematic approaches and points of view, or schools of psychotherapy. These courses may be on a cognitive rather than an experiential level. But experiential material can be introduced into these courses in varying ways. The reading in the list above is one way. Another way is the use of verbatim typescripts of therapy cases. In addition to typescripts, recordings of cases or interviews can be used; usually recordings and typescripts of the same interviews are

desirable. These can be used to illustrate various stages of therapy with a variety of clients having different problems, and of various therapy orientations. Sound films may also be useful. Students may also observe and listen to actual therapeutic interviews.

These techniques provide mainly vicarious experience. A more direct kind of experience is provided by the use of role-playing. Students can role-play with each other, or even actually counsel each other; in some cases role-playing may develop into counseling. These sessions may be recorded and then replayed for analysis and discussion.

Actual participation in therapy, either individual or group, is also, as suggested above, useful in the training of therapists.

PRACTICUM TRAINING

There is no substitute for actual practice under supervision in the training of counselors and psychotherapists. The necessity of such supervised practice prior to the assumption of independent counseling activity should be obvious. Wrenn (19) has pointed out that "it is just as disastrous to turn a personnel worker loose upon society without experience under supervision as it is to turn out a medical student without his internship." Various committees of the American Psychological Association, and of the National Vocational Guidance Association (1, 2, 3, 4, 5, 8, 11) include supervised practice in their recommended training programs for students at both the doctoral and subdoctoral levels. One of these committees states that "the practicum is in some respects the most important phase of the whole process of training in counseling" (2). There is no apparent disagreement with this position. Limitations in practicum training are the result of the high cost of such training, the difficulty of providing adequate facilities, and the problem of providing an adequate source of clients.

The point in the training of counselors at which experience in counseling actual clients should be introduced is not universally agreed upon. While it seems to be accepted that practicum ex-

periences should begin early in the training of clinical and counseling psychologists, these early experiences are limited to observation, incidental contacts with clients, and administration of tests. Although as Embree (7) states, "The training of counselors, from its earliest formalized beginnings, has been marked by some sort of guided and supervised practice with parts of the counseling process," this practice has been extremely varied and usually minimal. Actually, there are many institutions that do not include any significant amount of supervised practice in the counselor training program.

The nature of practicum training varies from field trips to a formal and standardized internship. It includes all varieties of field training from observation through test administration to intensive psychotherapy.

Obviously, the basic purpose of the practicum course is to provide supervised actual experience with a variety of clients. The student should have experience with a variety of clients presenting a variety of counseling experiences and problems. It is not enough, however, to offer just this practical experience. In addition, the practicum has at least two other major goals. The first is to assist the counselor in developing a professional attitude. This includes a familiarity with professional counselor organizations (The American Psychological Association and the American Personnel and Guidance Association and their Divisions), with professional journals (including the publications of the two Associations listed), and with the ethical responsibilities of the counselor.

The other major purpose of the practicum course is to aid the counselor in acquiring a systematic approach to counseling, or a philosophy for working with individuals in need of assistance. More important than the learning of techniques is the development of principles and attitudes. The student should know not only what he is doing, but why, in terms of a theory or philosophy.

This approach is not the method which Rogers appears to prefer. Rather than using a theory as a basis on which to integrate

experience, he feels that "theory, to be profitable, must follow experience, not precede it. . . . To train the student, prematurely, in a theory of personality, or even in a variety of such theories, results all too often in a dogmatic and closed-mind approach to experience" (16, p. 440). On the other hand, to operate with no theory, or general principles, such as a philosophy or system of attitudes toward human beings, or clients, would seem to leave the student floundering in a welter of techniques with no basis on which to use them.

A SYSTEMATIC APPROACH

If the development of a philosophy or a system of principles and attitudes is to become a goal of the counseling practicum, then a choice must be made among the available systems or points of view. It does not seem to be possible, or practicable, to present more than one point of view without confusing the student in his practice and leaving him without a consistent or systematic point of view at the conclusion of the course. There are some who may prefer this. The bias of the author is toward a systematic, theoretically based approach.

From among the possible points of view toward counseling and psychotherapy, the client-centered approach is adopted by the author. This means that the student is, if you will, indoctrinated in this approach. That the student is indoctrinated in some approach—albeit an unsystematic or eclectic one in some cases—seems inevitable, instructors being human and having preferences and biases. It would appear to be necessary that a choice be made, and that students be made aware of it.

Rogers has written that

The first step in training client-centered therapists has been to drop all concern as to the orientation with which the student will emerge. The basic attitude must be genuine. If his genuine attitudes lead him in the direction of some other orientation, well and good . . . no therapist can or should be trained to become a client-centered therapist (16, p. 432).

And again:

I believe that the goal of training in the therapeutic process is that the student should develop his own orientation to psychotherapy out of his own experience. In my estimation every effective therapist has built his own orientation to therapy within himself and out of his own experience with his clients or patients. It is quite true that this orientation as finally developed may be such that it closely resembles that of others, or closely resembles the orientation to which he was exposed. Nevertheless, the responses made by the effective therapist in his interviews are not made in a certain way because that is the psychoanalytic way, or the client-centered way; they are made because the therapist has found that type of response effective in his own experience. Likewise, he does not put on certain attitudes because those are the attitudes expected of an analyst or client-centered therapist or an Adlerian. He discovers and uses certain attitudes in himself which are developed because they have been rewarded by the effective outcome of earlier experiences in carrying on therapy. Thus the aim of a training program in therapy should be to turn out individuals who have an independent and open attitude toward their own experience in working with clients. If this is achieved, then they can continually formulate and reformulate and revise their own approach to the individuals with whom they are working in such a way that their approach results in more constructive and effective help (17, p. 87).

This sounds quite unlike the rigidity attributed to client-centered therapy, and almost eclectic in nature. The writer finds himself unable to follow it completely. In so far as it applies to specific methods and techniques, there is agreement. Certainly everyone develops his own particular or peculiar specific techniques and approach. But there are some difficulties and questions. How does one train therapists without any concern for what kind of a therapist emerges? What is the content of the instructor's contributions? Will not what he is or believes speak as loudly in his actions as words? It seems, however, that Rogers is not actually saying that students should not be exposed to the client-centered point of view.

If the client-centered approach is the best approach, how can the instructor be unconcerned about the kind of orientation with which the student will emerge? If, as is possible, the client-centered approach is the distillation of the necessary and sufficient

conditions of psychotherapy (18), how can a therapist be successful without accepting and applying them? If the essence of therapy is the attitude of unconditional positive regard and the essential condition that the therapist understand the client, how can these be ignored by the student or would-be therapist? It is true that few students do not "take" to the client-centered approach when they are exposed to it, but they must be exposed. An authoritarian personality would not be congenial to client-centered therapy. Indeed, such a personality would not be easily accepted or welcomed in any of the major schools of psychotherapy today, and it appears that few such persons choose counseling or psychotherapy as a career.

Apparently Rogers does not feel that the student should be "taught" a client-centered point of view; but by being exposed to client-centered, or student-centered, teaching, he would tend to become client-centered in orientation (16, p. 441). There is a distinction between classroom teaching and writing a text, however. In the latter one may, perhaps should, explicitly adopt a point of view.

The author openly espouses and develops a client-centered approach in his teaching. No student is required to accept it, of course. However, in the practicum, no student is allowed to attempt to be an amateur psychoanalyst. As one client-centered instructor put it, "We are training client-centered therapists, not half-baked psychoanalysts." The instructor has some responsibility to the clients, and it appears to the writer that the safest approach for the beginning student is the client-centered method. A student who wants to practice analytic or any other method of therapy can obtain training or experience in it later. Of course, no student is forced to conform to a specific technique. The expression and implementation of the philosophy and principles bear the marks of the students' personalities.

It is not to be expected, nor is the attempt made, to develop psychotherapists in a semester course. Even a much longer time

would be insufficient. But sufficient supervised experience can be given along with the readings to enable the student to develop to the point of being at ease with a client, and to assure that each new client is not looked upon with anxiety and apprehension. In addition, through an understanding of the counseling process based upon actual experience and coordinated with the development of a systematic approach, a philosophy can be achieved. Finally, the student can be assisted, providing sufficient basic capacity is present, to begin to develop a therapeutic personality, or perhaps to recognize that psychotherapy is not for him.

It is not the purpose of this book to provide experiential materials for a practicum or prepracticum course. Such materials are becoming increasingly available in the form of case books, type-scripts, recordings and sound motion pictures. Also, in the practicum course the materials for analysis, both in class sessions and individual supervision, come mainly from the students' own experiences.

The purpose of this book is to provide the student with a systematic approach to counseling and psychotherapy. The approach is client-centered. The systematic development of principles and practices of psychotherapy is derived from a general psychological theory of human behavior, namely phenomenology. This theory, or approach, seems to encompass the entire field of human behavior and human relations. Details of the theory vary among its proponents, and there will no doubt be future modifications, but it seems capable of contributing to the understanding and integration of the diverse aspects of human behavior. This theory, in turn, is related to a socio-cultural base including a discussion of values and ethics in psychotherapy. The system is sketched only in broad outline. As such, it provides a skeleton or framework upon which the student can build a philosophy of counseling and psychotherapy, filling in the details.

The purpose of this book, then, is to present materials with which to prepare the student to enter into therapeutic relationships

with clients. Ethical principles, the place of values in counseling and psychotherapy, and the socio-cultural background of personality development and therapeutic personality change are discussed as the background for the counseling relationship. The counseling relationship is thus placed in a systematic, or theoretical approach to human behavior. Principles and methods of counseling and psychotherapy are discussed in the broad setting of a theory of human behavior and human relationships.

REFERENCES

1. American Psychological Association, Committee on Training in Clinical Psychology. Recommended graduate training program in clinical psychology. *Amer. Psychologist*, 1947, 2:539-558.
2. American Psychological Association, Division of Counseling and Guidance, Committee on Counselor Training. Recommended standards for training counseling psychologists at the doctorate level. *Amer. Psychologist*, 1952, 7:175-181.
3. American Psychological Association, Division of Counseling and Guidance, Committee on Counselor Training. The practicum training of counseling psychologists. *Amer. Psychologist*, 1952, 7:182-188.
4. American Psychological Association, Education and Training Board, Committee on Subdoctoral Education. The training of technical workers at the subdoctoral level. *Amer. Psychologist*, 1955, 10:541-545.
5. American Psychological Association and the American Association for Applied Psychology, Subcommittee on Graduate Internship Training. Graduate internship training in psychology. *J. consult. Psychol.*, 1945, 9:243-266.
6. Brody, B., & Grey, A. L. The nonmedical psychotherapist; a critique and a program. *J. abnorm. soc. Psychol.*, 1948, 43:179-192.
7. Embree, R. B., Jr. The use of practicums and internships in counselor training. *Educ. psychol. Measmt.*, 1951, 11:752-760.
8. Institute for Human Adjustment. *Training of psychological counselors*. Ann Arbor: University of Michigan Press, 1950.
9. Krout, M. H. (Ed.) *Psychology, psychiatry, and the public interest*. Minneapolis: University of Minnesota Press, 1956.
10. Louttit, C. M. Training for non-directive counseling: a critique. *J. clin. Psychol.*, 1948, 4:236-240.
11. Miller, L. M. (Ed.) *Counselor preparation*. Washington: National Vocational Guidance Association, 1949.
12. Mowrer, O. H. Training in psychotherapy. *J. consult. Psychol.*, 1951, 15:274-277.

13. Patterson, C. H. *Counseling the emotionally disturbed*. New York: Harper, 1958.
14. Pepinsky, H. B., & Pepinsky, Pauline N. *Counseling theory and practice*. New York: Ronald, 1954.
15. Rainy, V. C. (Ed.) *Training in clinical psychology*. New York: Prentice-Hall, 1950.
16. Rogers, C. R. *Client-centered therapy*. Boston: Houghton Mifflin, 1951.
17. Rogers, C. R. Training individuals to engage in the therapeutic process. In C. R. Strother (Ed.), *Psychology and mental health*. Washington: American Psychological Association, 1956.
18. Rogers, C. R. The necessary and sufficient conditions of therapeutic personality change. *J. consult. Psychol.*, 1957, 21:95-103.
19. Wrenn, C. G. The basis of training for personnel work. *J. higher Educ.*, 1948, 19:259-261.

PART II

**BACKGROUND FOR COUNSELING
AND PSYCHOTHERAPY**

CHAPTER 3

Ethics and Counselor Needs

Every profession has a code or system of ethics. Every professional person is expected to conform to or live up to the established or prescribed code. Ethical problems arise in any field which is concerned with relationships with people. Standards which can be applied in the solution of these problems constitute the ethics of the profession. Such standards do not come by fiat, but develop out of experience. Psychological counseling is a relatively new profession; its standards and code of ethics are only in the process of developing. Nevertheless, there is enough general agreement in many areas to warrant discussion in a book addressed to counselors in training. Several recent texts in counseling (e.g., 3, 8) discuss some of the ethical problems in counseling, but none gives this area the attention which it deserves.

Concern with ethics in psychology is of rather recent origin. It coincides with the development of psychology as a profession. One of the first attempts to formulate a code was that of Sutich (16). His major concern was with the relationship between the client and the counselor. As a result, he developed, in effect, a system or philosophy of counseling rather than a code of ethics. Sargent (12) modified some of his principles, which had been presented

mainly as rights and duties of the client and the counselor. Meehl and McClosky (11) point out the resulting confusion of ethics and techniques. Bixler and Seeman (2) later offered some suggestions for a code, indicating the relationship of professional ethics to social values. This relationship will be discussed in the next chapter. Gluck (6) has presented a proposed code of ethics for counselors, utilizing material collected from medicine, law, social work, and psychology.

The American Psychological Association (APA) has been concerned for some years with the development of ethical standards in psychology. Its publication, *Ethical Standards of Psychologists* (1), although presently in the process of revision, constitutes the handbook of ethical practice in the profession. Every counselor should have a copy in his library. The present chapter will draw upon this source in the areas which it covers. Although the term psychologist is used throughout this document, it should be interpreted as including counselors. There have been few discussions of the application of ethical principles in counseling. That of Wrenn (22) constitutes the most extensive to date, and will be drawn upon in our later discussion.

THE COUNSELOR'S RESPONSIBILITIES

No client lives in a vacuum. He has relations with family, relatives, friends, and with society at large. The counselor also has relationships with employers, colleagues, the counseling profession, and with society at large. Counseling a client is affected by all these relationships. The counselor thus has responsibilities to various persons and groups besides the client. It is agreed that the counselor's major responsibility is to the client; but he also has responsibilities to the family and relatives of the client, to a referring agency, to his own agency or employer, to his profession, to society in general, and lastly, to himself.

RESPONSIBILITY TO THE CLIENT

As just stated, the counselor's primary responsibility is to the

client. The purpose of counseling is to assist the client in achieving a more adequate life, whether in terms of vocational, marital, social or personal adjustment, or in terms of greater satisfaction with himself. The goal is not adjustment to society for the sake of society; the goal is rather in terms of what is best for the client. This is expressed in the APA code of ethics as follows: "A cardinal obligation of the clinical or consulting psychologist is to respect the integrity and protect the welfare of the person with whom he is working. Vigilant regard for this principle should characterize all of the work of the psychologist and pervade all his professional relationships. . . . Clinical services must not be imposed upon an individual, nor should a person be unduly urged to avail himself of such services" (1, p. 49). Counseling is a voluntary relationship, from which the client may withdraw at any time.

This responsibility to the client does not mean that the counselor must accept any and all goals which the client proposes, and assist him in all possible ways to achieve them. The counselor is first of all interested in psychological goals, or goals which can be achieved through psychological means, i.e., therapeutic counseling. Nor does it necessarily mean that the counselor must accept the client's expressed needs or preferences in regards to his goals or means of achieving them. The counselor is a professional person; and the profession to which he belongs has certain concepts of the goals of counseling and psychotherapy. Hahn and MacLean express these goals as follows: "Most leaders in the field agree that the desired outcome of counseling is self-realization and self-direction on the part of the client" (8, p. 24). Another way of putting it would be to say that the object of counseling is to enable the client to achieve independence and the ability to take responsibility for himself and his actions.¹ The goals of the client and the counselor usually coincide; sometimes, however, the

¹ See Chapter 4 for a more extensive discussion of the goals of counseling and psychotherapy.

client's goals may be short-term, or shortsighted, or may be inconsistent with the goals of counseling. The client may want to be dependent, rather than to become independent. In such a case, there is a question as to the counselor's ethical responsibility. Meehl and McClosky (11) state that "The most fundamental ethical commitment of the counselor is to help the client achieve the client's end," and that "any 'philosophy of counseling' which acquires a structure so rigid that it even occasionally inhibits the counselor from taking steps which would psychologically facilitate this attainment is unethical or doctrinaire." But when the desires of the client are not consistent with the best thinking of the profession, a conflict of responsibility ensues. This is only one illustration of the conflict of responsibilities which the counselor faces. It also is an example of the relationship between ethics and values, which we shall consider later (Chapter 4).

The counselor has another responsibility to the client, which is sometimes also classed as a responsibility to the profession. This is the responsibility to maintain high standards of work. It involves the choice of techniques, which again sometimes implicates him with values. Meehl and McClosky (11) attempt to divorce techniques from values by insisting that choice of techniques must be based solely on their effectiveness in achieving the goals of counseling. But, as indicated above, goals are values, and not all counselors accept the ultimate goals discussed above as applicable in every case of counseling. Different goals require different techniques, so that we cannot therefore divorce techniques from goals, or means from ends. But "as a practitioner, the psychologist should strive at all times to maintain highest standards in the services he offers" (1, p. 4). "The psychologist in clinical and consulting practice, mindful of the significance of his work in the lives of other people, must strive at all times to maintain highest standards of excellence, valuing competence and integrity more than expedience or temporary success" (1, p. 39).

If these standards are not always clear and specific, the coun-

selor can only use his judgment based on his training and experience. The counselor, therefore, has the responsibility for adequately preparing himself professionally for working with clients with varying types and degrees of maladjustment. Of just what this preparation should consist is, as suggested in the previous chapter, not agreed upon completely. It should include a minimum of one to two years of graduate work, including some practicum experience, either in a practicum course or through supervised experience.

This responsibility to maintain high standards also includes the recognition of one's limitations, and the refusal to practice beyond one's level of competence. "Psychologists in all fields should recognize the boundaries of their competence and not offer services which fail to meet professional standards established by recognized specialists in particular fields" (1, p. 17). "It is unethical for a psychologist to offer services outside his area of training and experience or beyond the boundaries of his competence" (1, p. 44).

Where the counselor is aware of his lack of competence in a particular case, he has the responsibility of obtaining consultation or of making a referral. "In clinical or consulting practice the psychologist must refer his client to an appropriate specialist when there is evidence of a difficulty with which the psychologist is not competent to deal" (1, pp. 78-79). "It is unethical for an individual to claim either directly or by implication professional qualifications that exceed those he has actually attained. The individual is responsible for correcting others who misrepresent his professional qualifications" (1, pp. 23-24). This seems to be clear, though there are times when it is difficult to apply. A common problem is where the client confuses the counselor with a physician or, more frequently, with a psychiatrist. It is clearly the counselor's responsibility to correct such an impression. This sometimes requires the defining of the differences between a counselor or a psychologist, and a psychiatrist.

Schwebel (13) attempts to differentiate between unethical

behavior, which is the result of self-interest, and unethical *practice*, which is the result of unsound judgment because of inadequate training or experience. The distinction is a justifiable one in that it differentiates between selfish interests and errors. But the distinction is not always clear, e.g., in the case where poor judgment results from inadequate training because of the refusal of the counselor to withhold himself from practice until he is adequately trained. At any rate, whatever the cause or motive, the practice is unethical.

RESPONSIBILITY TO THE CLIENT'S FAMILY AND RELATIVES

It often happens that the client's family and associates have a stake in his situation. They may have urged or forced him to seek help, or have brought him for help, as in the case of children. They are often genuinely interested in the progress of counseling, and in how they can assist the process.

It is generally accepted that the counselor will have no professional contact with the family or friends of the client, without first having the permission of the client to do so. In situations where the other persons associated with the client may be in danger, an exception may have to be made. But even here the counselor should first ask permission and if refused, tell the client that he feels he must go ahead and talk to them even if the client does not wish it. This is a problem only with seriously disturbed clients, and usually permission is granted.

The problem arises of what is to be told to the parents or relatives. It usually is not necessary to violate the confidences of the client, or if it seems desirable to do so, it should be done only with the express permission of the client, except, again, where the client is clearly mentally irresponsible. The nature of the client's condition can be made clear without violating confidences. The author recalls the case of a client who developed a paranoid delusion regarding his wife's unfaithfulness. He granted permission for his wife to see the counselor—his wife had requested a

consultation, but the client was consulted first. It was possible to explain his condition to the wife, and to apprise her of the fact that she was in danger, without going into confidential details regarding the nature and origins of his delusion. Hospitalization was recommended, and the family arranged for this with the assistance of the counselor.

RESPONSIBILITY TO THE EMPLOYER

Where the counselor is employed in a counseling agency, school, or other organization, he has certain responsibilities to the agency or employer. There is a responsibility to accept and work with only those clients who are eligible for the services of the agency. An agency or school dealing with clients who are minors has responsibilities to the parents of the clients, and the counselor is involved in these responsibilities. The agency or counseling bureau may have responsibility to the larger organization, that is, the school or the college. This responsibility affects the counselor.

The confusion of administration with counseling creates many problems. These have not been resolved, and are a source of conflict for many counselors. Counseling has often been, and still is in many cases, an adjunct to administration (2, 19). The APA code of ethics states that "Individuals and agencies in psychological practice are obligated to define for themselves the nature and directions of their loyalties and responsibilities in any particular undertaking and to inform all concerned of these commitments" (1, p. 42). This is not always easy to do, however, and there are some obligations or responsibilities that are incompatible with each other.

As an example, limitations of resources may preclude a long-term relationship with a client who requires it for the resolution of his problems. The counselor must decide between either accepting the client for limited service, or declining to begin to work with him since it doesn't appear to be possible to achieve the desired goals of counseling. In many instances, it is possible to

modify or expand the agency's services. Sometimes it may be necessary for the counselor to resign his position, if he feels that continuing is incompatible with his concepts of professional practice. This has happened, for example, in some school situations where administrative action of a disciplinary nature has been part of the counselor's function, and the counselor felt unable to reconcile this function with his counseling function.

RESPONSIBILITY TO REFERRING SOURCE

It often happens that a client is referred to the counselor by another professional person or agency. In the school situation it may be the teacher who refers the client. In other situations it may be a supervisor, a superior in the work situation, or the employer. Or it may be another counselor, a physician, or a social agency. What is the counselor's responsibility to these persons? To some extent the responsibility varies with the professional status of the referring source. Nonprofessional referral sources may be dealt with somewhat as with relatives or friends. Even in the case of professional personnel, however, the client is consulted before transmitting confidential information, unless it was made clear to the client by the referring source that the purpose of the referral was to obtain such information. Even where there is to be no continuing professional contact of the client with the referring source, or where the referring individual has no need for information, it is courtesy, if nothing more, to communicate with the referring source regarding the outcome of the referral. If there is a continuing relationship between the referring individual and the client, there may be an interest in the opinions or recommendations of the counselor with regard to handling the client. If there is no continuing contact, the referring individual should be informed that the client kept the appointment, that he is or is not going to continue in a counseling relationship, or that further referral is being made, etc. The nature of information and recommendations

given to teachers or others concerned with the client will be dealt with later in this chapter.

RESPONSIBILITY TO THE PROFESSION

In the section on responsibility to the employer, the conflicts described may be viewed as between responsibility to an employer and to the counseling profession. The counselor has a responsibility to so represent his profession that it does not suffer in the eyes of clients and the general public. The maintenance of high standards of service is a responsibility to the profession as well as to the client.

The counselor has a responsibility not only to his own profession but to all helping professions generally to avoid condemnation or criticism of another's methods or approach. However, he also has a responsibility to inform the appropriate professional body or organization when he has evidence of unprofessional or unethical practice, so that steps may be taken to protect the profession as well as the public from an offending practitioner.

When a psychologist becomes aware of practices likely to result in the offering of inferior professional work or in the lowering of standards for psychological service, he should exert what influence he can to rectify the situation (1, p. 47).

In circumstances where psychologists or persons identifying themselves as psychologists violate ethical standards or offer inferior professional service, it is the obligation of psychologists who know firsthand of their actions to attempt to rectify the situation. In some instances, violations of ethical standards can be handled most constructively by personal communications; in others, the psychologist involved should report the details to the appropriate ethics committee. Choice of procedures in each instance should be determined by the interest of the public, of the people involved, and by a consideration of probable effectiveness of alternate courses of action (1, pp. 19-20).

RESPONSIBILITY TO SOCIETY

The source of some of the counselor's greatest conflicts lies in the relation between the responsibility to the client and to society. The counselor's primary responsibility is to the client, but "the

psychologist's ultimate allegiance is to society, and his professional behavior should demonstrate an awareness of his social responsibilities" (1, p. 7). "When the two responsibilities are in conflict, it takes fine ethical distinctions sometimes to decide which is paramount" (8, p. 35). It is suggested that the counselor discharges his responsibility to society by counseling the client, since, if counseling is successful, presumably the problem will no longer exist. "The clinical or consulting relationship can develop most fully only in an atmosphere of trust, and . . . the psychologist can often serve society most effectively not by revealing confidences of antisocial events or intentions but by helping the individual realize himself as a socially competent and responsible person" (1, p. 56). Bixler and Seeman (2) say that the primary responsibility to society is to use one's skills in the service of each client to aid him in dealing with his problems. However, it is sometimes the case that the client's antisocial behavior is so flagrant and so persistent that action cannot wait. Minor pilfering of a kleptomaniac nature may be ignored if counseling is progressing. But what about the case where the client announces his intention of committing a major criminal act?

Clearly, society must be protected. Also, the client himself must be protected in certain instances. In these cases, intervention of the counselor in the client's life, whether to protect the client or others, may be justified when it is determined that the client, because of his mental condition, is unable to take responsibility for himself or his actions. Caution must be used in resorting to such action, to avoid using this means to justify intervention in the client's life, and thus violating his personal integrity.

Counselors vary in the extent to which they weight their relative responsibilities to the client and to society. As Wrenn (22) points out, conformity is more highly valued by some counselors, while others value placing the individual above the group. It is, thus, no easy matter to determine when the demands of society take precedence over the freedom of the individual. The APA code states

that "The psychologist should guard professional confidences as a trust and reveal such confidences only after most careful deliberation and when there is clear and imminent danger to an individual or to society" (1, p. 55). But it is not always easy, in the psychological realm, to determine what constitutes a clear and imminent danger to society. In some areas this is relatively clear; Thorne (18) points out that doctors must report tuberculosis, venereal disease, and gunshot wounds—the public health and welfare aspects taking precedence over the desires of the individual. Thorne allies himself rather strongly with society. Wrenn appears to side more with the individual, stressing the primary responsibility to the client, except in threatened suicide, homicide, or treason. Each counselor must make his own decisions in each case (10).

RESPONSIBILITY TO HIMSELF

In addition to his responsibilities to the above individuals and groups, the counselor has some responsibility to himself. Thorne (18) views this responsibility in terms of protecting one's reputation. But it goes farther than this. The counselor is himself an individual with certain rights. He has a right to his private life, and to preserve this from invasion by excessive demands of clients. Psychiatrists seldom, if ever, make house calls—the cartoon of the psychiatrist walking down the street carrying his couch, captioned "Psychiatrist making a house call," strikes us as humorous. It is no doubt true that there are good professional reasons for not attempting therapeutic counseling in the client's home, but it is also true that "There are no psychiatric emergencies." Some psychiatrists do not accept phone calls after a certain hour—a fact which makes for the envy of other physicians, and some difficulty in the relationships of psychiatrists with other physicians, particularly in a clinic setting. The author has had telephone calls from clients in the middle of the night. But they have been few, because they were not encouraged, or suggested, or mentioned, and the

counseling relationship established was not one of such dependence on the counselor. Dependency, often encouraged by the counselor, leads to the client placing demands on the counselor which interfere with his private activities. Such excessive demands should not be encouraged.

In addition to overt demands by the client, the counselor should avoid placing demands on himself to conform to the assumed needs or desires of the client. Nor should he yield to the expressed wishes of the client in regard to his method of counseling. That is, he should not compromise his own professional training, judgment, hypotheses, or even beliefs at the request of the client. If he feels that, for whatever reason, his approach to the client is apparently not effective, he has the right to refuse to practice another approach, or to resort to palliative methods or other methods inconsistent with his principles. In such a situation, the client, of course, is free to leave; and if he desires, should be assisted in contacting a counselor who may be able to work with him on a different basis.

Finally, the counselor must not become so involved in the problems of his clients that he cannot leave these problems at the office, unless he desires to review them later for a particular reason. A counselor who cannot keep from being preoccupied or worried by his clients' problems should find another profession. Related to this is concern, or overconcern, about the progress and outcome of his counseling. A counselor who expects too much of counseling, who wants complete or miraculous cures, is demanding too much of himself and of his profession. His responsibility to himself to engage in a satisfying occupation is being denied.

MULTIPLE AND CONFLICTING RESPONSIBILITIES

It is easily seen that the responsibilities of the counselor are great and varied. More than this, they are, as we have seen, sometimes mutually incompatible. Fortunately, conflicts arise in only a minority of cases. Certain types of conflict are sometimes more

frequent in certain situations. Codes of ethics are helpful—indeed essential—but they do not solve individual problems. Particularly where there are conflicting responsibilities or loyalties, they can do little more than point out the several obligations. The counselor must make the decision, which often must be a compromise if the conflicting obligations cannot be reconciled, or if one of them cannot be placed definitely above the other. Some of the conflicts, e.g., those between the individual and the group, cannot be completely reconciled, and one's decision, as suggested above, is dependent on one's own set of values, upon one's own preference for one of two value systems which are in conflict within our society. Ethical principles, therefore, as Wrenn (22) points out, must be based upon a value system. Consideration will be given to this relationship in the next chapter.

There are many other questions of an ethical nature which will arise in counseling, which cannot be covered here. The recording of interviews sometimes raises problems. It is generally agreed that, except in unusual circumstances, the client's permission is obtained before recording an interview. Another rather common problem is that of the client who is being seen by another professional person. "A psychologist should not normally accept for diagnosis or treatment a person who is receiving psychological assistance from another professional worker except by agreement or after termination of the client's relationship with the other professional worker" (1, p. 81).

CONFIDENTIALITY OF INFORMATION

The matter of confidentiality of information has been mentioned in our discussion of the responsibilities of the counselor. However, it is of such importance and has so many implications that it deserves separate treatment.

Confidentiality of information involves the concept, or right, of privileged communication. Lawyers, physicians, and the clergy usually enjoy privileged communication by law. State codes usually

provide that members of these professions may not testify against persons on the basis of information obtained in a confidential professional relationship except with the permission of the person involved. Such laws do not specify that psychologists or psychological counselors have this privilege. In one instance (1, p. 12; 14), it was ruled that a psychologist did not qualify for the privilege. A counselor could refuse to testify and be cited for contempt of court, and thus provide a test case. There is no precedent for a decision, other than the rulings of a judge. Wrenn (22) presents an excellent discussion of the legal status of psychologists with regard to confidentiality of information. He points out that the counselor certainly does not have to disclose such information unless under oath, and that there is no legal obligation to reveal violations of the law. He suggests that, since the information is usually based only on statements of the client, it is actually only hearsay. The APA code of ethics states that "In the absence of legislation or judicial ruling to the contrary, a psychologist may take the position that he enjoys the same status with regard to privileged communications with clients as do other professional workers offering comparable professional services to the public" (1, p. 13).

While the counselor is not legally required to divulge confidential information, he is ethically obliged *not* to reveal it, that is, unless he decides that his obligation to society takes precedence over his obligation to the client in a particular situation (10). Schwebel (13) believes that "information received in confidence as a professional worker must not be revealed under any circumstances even to achieve desirable ends." Diamond and Weihofen (4) state that "Wholly apart from any legal privilege, it would be a breach of professional ethics for a therapist not to respect his patient's confidences," but they add, "so far as the law allows."

It is generally agreed that confidential information may be discussed with professional persons under certain circumstances. "Information obtained in clinical or consulting relationships should be discussed only in professional settings and with pro-

fessional persons clearly concerned with the case" (1, p. 56). But who are professional persons? Clearly, the supervisor of a student would be considered as such. Also, staff members of a clinic or counseling bureau would qualify. In such situations, it is customary to discuss client's problems in case conferences without necessarily obtaining specific permission from the client. It is assumed that the client is aware of the practice, and knows that records are kept and are accessible to staff members of the agency. It appears to be desirable, nevertheless, to request the client's permission to use the information in case conferences if there is any question that he might not be willing. However, where the counseling agency is part of an administrative organization, conflicts may arise. Should confidential records be accessible to administrators, such as deans; to faculty members; to student trainees; to residence hall "counselors"? Many counselors believe not, yet it is customary practice in most counseling bureaus in colleges and universities.

The APA code states that "In clinical and consulting situations where possible division of loyalties exists, as between the client and the employer of the psychologist, agreement concerning handling of confidential materials must be worked out and the nature of the agreement made known to all concerned" (1, p. 56). This may not always be easy to do, or even possible. Where it is not, some counselors keep two sets of records, one for general agency use, and one for their own private use. Or sometimes they depend on their memory for highly confidential information, making no note of it in their records. This would seem to be justified in situations where the records could or do come into the hands of nonprofessional people. It is also suggested that "When the psychologist's position is such that some departure is required from the normal expectation that clinical or consulting relationships are confidential, it is expected that the psychologist will make clear to the client the nature of his role before the client enters the relationship" (1, p. 56). In other words, if information may be used against the client, he should be warned, even if it affects, destroys, or prevents the counseling relationship.

In the public school situation, are teachers "professional" persons? Usually they are not. Yet they are interested in the students they teach and whom they refer to the counselor. There are other nonprofessional persons with whom the counselor may discuss his clients. Where they are not strictly professionally trained persons, however, the counselor should not divulge the details of his knowledge of the client, except with the express permission of the client. People concerned with the client may have some rights to learn about the client. These rights do not include the right to share confidential information. The counselor must decide what he can tell the individual concerned, whether parent, guardian, teacher, or probation officer. "The psychologist should give clinical information about a client only to those persons whom the client might reasonably be expected to consider a party to the psychologist's efforts to help him. The client's concurrence should be obtained before there is any communication exceeding these customary limits" (1, p. 63). "The psychologist is expected to present his clinical findings accurately and with candor in language that facilitates assimilation, and in such a way as to promote the welfare of the client" (1, p. 65). As Bixler and Seeman (2) point out, suggestions and recommendations may be made without revealing confidences.

It should go without saying that the counselor, or student in training, does not discuss his cases with his friends, with fellow students, or with teachers over coffee, at lunch, or in other casual situations. Such practices generally become known, with the result that the counselor's potentiality for helping clients with personal problems is destroyed. Students know, or learn, whom they can trust with confidences.

INFLUENCE OF THE COUNSELOR'S PERSONALITY AND NEEDS

The personality of the counselor affects the counseling relationship. We are concerned here with the influence of the counselor's

needs upon counseling, to the extent that they lead to a counseling relationship which is not such as to provide the best opportunity for the client to progress toward the goals of the counseling process. In this sense, the personal needs of the counselor may interfere with counseling, and may result in what Schwebel (13) terms unethical practice if not unethical behavior.

Our first concern is with the general psychological adjustment of the counselor. Concern of the counselor with his own problems of adjustment may obviously interfere with his offering an appropriate relationship to the client. "It is desirable that a psychologist engaged in clinical or consulting work, where sound interpersonal relationships are essential to effective endeavor, be aware of inadequacies in his own personality which may bias his appraisals of others or distort his relationships with them, and refrain from undertaking any activity where his personal limitations are likely to result in inferior professional services, or harm, to a client" (1, p. 46). Selection procedures are used in the attempt to prevent seriously disturbed persons from entering the field of counseling. It is not possible to draw a definite line when it comes to minor maladjustments, however. All of us are to some extent "queer," or have problems. Those who have had serious problems and have resolved them may be highly capable of helping others. Personal therapy may enable those with minor problems to function more effectively as counselors. The didactic or training analysis of psychoanalysts is required to enable them to avoid having their own problems interfere with their therapy.

Even the relatively well-adjusted individual, however, must be aware that his own needs, some of them perhaps somewhat exaggerated or overly strong, others normal, may affect his counseling. Training in counseling, therefore, should help the individual develop an understanding of his needs and their effect on his counseling. The supervision in the practicum course attempts to do this on an individual basis.

There are some common problems in this area which may well be discussed here. Fromm-Reichmann (5) deals with some of the basic needs of the counselor in relation to counseling. She stresses the necessity of the counselor having enough sources of satisfaction so that he is not tempted to use his clients as sources. She points out the danger to the private practitioner, in starting practice, of becoming dependent on one client for the satisfaction of hunger. It goes without question that the counselor doesn't use his clients for sexual gratification. Nor should the counselor use the counseling hour to satisfy the need for sleep. She mentions the rationalization of therapists who say that they only fall asleep when the client is producing irrelevant material and wake up as soon as his talk is pertinent.² Wrenn (21) cautions counselors to recognize their fatigue points and to avoid counseling when fatigued. The counselor certainly has a responsibility to be at his best physically. Unfortunately, it is not always possible to be equally fresh and alert with every client. Listening requires alertness; the cartoon picturing two psychiatrists in an elevator at the end of the day, one fresh and alert, the other drooping with fatigue, is pertinent. The fatigued one is asking the other, "How do you listen to the troubles of patients all day and still look fresh?" To which the other replies, "Who listens?"

There are other, less obvious needs of the counselor which may affect the counseling situation. One is the need for social companionship—the avoidance of physical loneliness, in Fromm-Reichmann's words (5, p. 12). She recommends that one be thrifty with the expression of any physical contact with the client. The reverse of this need is present in some, i.e., the need to avoid contact with others, the desire to be aloof, isolated, uninvolved. This may represent a fear of being confronted with emotional

² This apparently refers to Ferenczi's statement (Ferenczi, S. *Missbrauch der Assoziationsfreiheit*. In *Bausteine zur Psychoanalyse*, II. Vienna: Int. Psychoanal. Verlag, 1927, p. 41): "The danger of the doctor's falling asleep . . . need not be regarded as grave because we awake at the first occurrence of any importance for the treatment." (Quoted by H. Racker. The meaning and uses of countertransference. *Psychoanal.*, 1957, 26:303-357.)

behavior by the client. If the counselor is embarrassed by such behavior, he will behave in such a way as to prevent it. He may assume a distant, impersonal attitude, keeping the discussion on a rational, intellectual plane, avoiding feelings and emotions.

The need for recognition and prestige may interfere with counseling. A counselor who desires strongly to be looked up to, respected, admired, to be considered clever, intelligent, and informed may seek satisfaction of this need in counseling. The beginning, inexperienced counselor may have a fear of appearing ineffective, or even stupid, and try to impress the client with his knowledge of psychology or psychiatry. Fromm-Reichmann quotes Freud as saying, "The psychoanalyst's job is to help the patient, not to demonstrate how clever the doctor is" (5, p. 19). Greenacre (7) says that "The analyst must forego the privilege of eliciting the patient's admiration for his personal exploits." Wyatt (23) points out that the therapeutic situation "offers gratifications for two of the deepest and oldest of our cravings: the wish to be liked and the wish to be important," the expression of which must be controlled in psychotherapy. The need to bolster feelings of insecurity may lead to encouraging dependence of the client on the counselor, or may result in attempts to push the client, by suggestion, persuasion, and other methods, to improvement, in order to enhance the reputation of the counselor, or to reassure the counselor that he is effective.

It would seem to follow that a counselor must have a feeling of security in himself and in his procedures, a sense of self-respect or self-esteem (7). Confidence in oneself makes unnecessary the attempt to cultivate the client's adulation, admiration, etc. Moreover, one can respect others only to the extent that one respects oneself (15, p. 7). This respect for clients keeps the counselor from assuming an attitude of superiority, authority, or omniscience—from playing God. It also makes it possible for him to admit his mistakes—both to himself and to the client when it seems desirable. It also enables him to avoid being threatened by the client's

criticism and hostility, and to avoid becoming anxious over, and thus increasing, the client's anxiety.

Another need of many counselors which affects their counseling is the need to teach. This is a common approach of beginning counselors who have had teaching experience. It is perhaps related to the need discussed above, in that often the teaching attitude includes a need or desire to be superior, to be dominant, to lead the client to the solution of his problems, or even to feel that the counselor must have the answers and should give them to the client.

This need may also be related to the need to be helpful, or the so-called social service drive. Counselors with a strong need in this area may desire to take a paternal or maternal role, to show kindness and sympathy. It may lead to their attempting to do things for the client, such as manipulating the environment, interceding for him, protecting him, etc.

Finally, we return to the influence of the counselor's own personal problems in the counseling relationship. These may affect counseling in either of two ways. On the one hand, the counselor may be preoccupied with his problems, and may be seeking a solution to them. As a result he may be sensitized to certain problem areas, or may even project his own problems into the client. This may also reflect itself in an overwhelming curiosity about certain areas of his clients' lives, the sexual, for example, so that he tends to probe into these areas and to uncover all the details. On the other hand, his own conflicts may blind him to certain problems, so that he avoids them or is unable to understand what the client is saying. It also sometimes happens that a counselor who has found, or feels he has found, a solution to his own problems attempts to impose his solution upon his clients.

Schwebel (13) has discussed motives of the counselor which lead to unethical behavior. He has included the need for self-enhancement and the need to maintain status and security. In addition, he has included the profit motive, which may lead to

continuing counseling with a fee-paying client beyond the point where it is necessary. Weitz (20) discusses the influence of insecurity. Wrenn's (21) discussion includes, besides the problem of counselor fatigue referred to above, the influence of lack of assurance, self-glorification, discouragement, the strain of indecision, and the temptation of authority.

As suggested above, none of us is free from the influence of our needs. None of us is free from biased attitudes and feelings. Even psychoanalysis does not purify the individual completely. The analyst still is a human being, with human weaknesses and foibles. We cannot, therefore, expect perfection in counselors. But we can require and assist the counselor to achieve some insight into himself, his motives, needs, and biases, and some recognition of how these affect his counseling relationships. This is one of the functions of the practicum course.³

REFERENCES

1. American Psychological Association. *Ethical standards of psychologists*. Washington: Author, 1953.
2. Bixler, R. H., & Seeman, J. Suggestions for a code of ethics for consulting psychologists. *J. abnorm. soc. Psychol.*, 1946, 41:486-490.
3. Bordin, E. S. *Psychological counseling*. New York: Appleton-Century-Crofts, 1955.
4. Diamond, B. L., & Weihofen, H. Privileged communication and the clinical psychologist. *J. clin. Psychol.*, 1953, 9:388-390.
5. Fromm-Reichmann, Frieda. *Principles of intensive psychotherapy*. Chicago: University of Chicago Press, 1950.
6. Gluck, S. *et al.* A proposed code of ethics for counselors. *Occupations*, 1952, 30:484-490.
7. Greenacre, Phyllis. The role of transference. *J. Amer. Psychoanalytic Ass.*, 1954, 2:671-684.
8. Hahn, M. E., & MacLean, M. S. *Counseling psychology*. (2d ed.) New York: McGraw-Hill, 1955.
9. Lawton, G. Neurotic interaction between counselor and counselee. *J. counsel. Psychol.*, 1958, 5:28-33.
10. Little, R. B., & Strecker, E. A. Moot questions in psychiatric ethics. *Amer. J. Psychiat.*, 1956, 113:455-460.

³ Further discussion of the counselor's personality in therapy will be found in the section on countertransference in Chapter 9.

11. Meehl, P. E., & McClosky, H. Ethical and political aspects of applied psychology. *J. abnorm. soc. Psychol.*, 1947, 42:91-98.
12. Sargent, Helen. Professional ethics and problems of psychotherapy. *J. abnorm. soc. Psychol.*, 1945, 40:47-60.
13. Schwebel, M. Why unethical practice? *J. counsel. Psychol.*, 1955, 2:122-128.
14. Shoben, E. J. Psychologists and legality: a case report. Letter to the Editor. *Amer. Psychologist*, 1950, 5:496-498.
15. Sullivan, H. S. *Conceptions of modern psychiatry*. Washington: William Alanson White Psychiatric Foundation, 1947.
16. Sutich, A. Toward a professional code of ethics for counseling psychologists. *J. abnorm. soc. Psychol.*, 1944, 39:329-350.
17. Szasz, T. S. On the experience of the analyst in the psychoanalytic situation: a contribution to the theory of psychoanalytic treatment. *J. Amer. Psychoanalytic Ass.*, 1956, 4:197-223.
18. Thorne, F. C. *Principles of personality counseling*. Brandon, Vermont: Journal of Clinical Psychology, 1950. Ch. 5.
19. Warnath, C. F. Ethics, training, research; some problems for the counseling psychologist in an institutional setting. *J. counsel. Psychol.*, 1956, 3:280-285.
20. Weitz, H. Counseling as a function of the counselor's personality. *Personnel Guid. J.*, 1957, 35:276-280.
21. Wrenn, C. G. "The fault, dear Brutus—" *Educ. psychol. Measmt.*, 1949, 9:360-378.
22. Wrenn, C. G. The ethics of counseling. *Educ. psychol. Measmt.*, 1952, 12:161-177.
23. Wyatt, F. The self-experience of the psychotherapist. *J. consult. Psychol.*, 1948, 12:82-87.

CHAPTER 4

Values and Psychotherapy

Most textbooks in counseling and psychotherapy contain no discussion of the problem of values. The neglect of this area in earlier courses thus means that when the student comes to the practicum, problems arise in his counseling. If he has been exposed to the client-centered philosophy, he is of course usually convinced that he should be nonjudgmental regarding the client's attitudes, beliefs, values, and behavior. Most other approaches to counseling agree upon this. However, this is not sufficient preparation for actually dealing with values in the therapeutic process.

There has been some concern with the place of values in psychotherapy, with psychoanalysts particularly giving this topic considerable attention. The generally accepted point of view has been that the therapist's values should be kept out of the therapeutic relationship. Wilder, commenting upon a paper by Ginsburg, puts it as follows: "It has been taken for granted that the analyst must not try to impose his value systems on the patient," and he adds: "and I still think this to be true" (9). In line with this "hands off" approach, therapists have been exhorted to become aware of their value systems, for the purpose of keeping their own values out of the therapy and to avoid deliberate or unintentional indoctrination of the client.

Perhaps few therapists feel that values should not be *dealt* with in psychotherapy. As Green (10) has pointed out, therapists *must* deal with values, since they are part of the personality of the patient, and the source of many of his problems. That some therapists still are uncomfortable in doing so seems to be indicated by Zilboorg's (52) defense of subjectivity, and his statement that while "the psychiatrist is not concerned primarily with moral problems, he does not reject them."

Recently there has been developing the realization that the therapist's own values cannot be kept out of the therapeutic relationship. Before examining this problem and suggesting how it should be handled, perhaps some attempt at defining values is necessary.

DEFINITION OF VALUES

There appears to be no generally accepted, simple definition of values. Williams (quoted by Ginsburg [8]), a sociologist, defines values as "affectively charged conceptual structures registered by the individual which act as directives. They form an important part of the apprehension of self and act as directional factors in the organization of behavior." Kluckhohn (17, p. 395), an anthropologist, defines a value as "A conception, explicit or implicit, distinctive of an individual or characteristic of a group, of the desirable, which influences the selection from available modes, means, and ends of action." Murphy, Murphy, and Newcomb (26, p. 199), writing from the social psychological point of view, state that a value is simply "the maintenance of a set toward the attainment of a goal," especially when the goal is remote. They tend to relate values to needs, in the sense that objects acquire value as means of satisfying a need. Murphy later (24, p. 270) states that "the central fact about values is that they arise from definite wants," so that a value is "the characteristic of an object which makes it desired or desirable or to be sought after." If object is defined as including other than material or concrete elements, and

wants as including psychological and social desires or needs, perhaps this definition can be accepted, at least as partially definitive. Smith (39), a social psychologist, states that "by values I shall mean a person's implicit or explicit standards of choice, insofar as these are invested with obligation or requiredness." Ginsburg (9), a psychiatrist, admitting that values are difficult to define, states that "values are preference statements which are related to generalized notions, principles, or conceptual constructs for which we use the noun '*a value*.'" Values are thus not simply derived from needs, appetites, or interests, which include valuation but are not values, but come into play when a choice must be made which is *not* decided simply on the basis of a need, but is influenced by the ego or ego ideal. In another place (8) he defines a value as "a criterion which helps us to distinguish between alternatives and affords us a base for recognizing ourselves in relation to the rest of the world." Values reflect needs and interests, but are neither of these. Neither are values simply goals, though they may be, but criteria against which goals are chosen.

It appears that a simple, generally acceptable definition of values is difficult if not impossible to formulate, but perhaps we can state some of the characteristics of value which seem to run through the definitions cited above. First of all, values are what might be termed hypothetical constructs. They are not objective—they are not objects, or goals, nor are they needs, interests, wants, or desires. But they are tied to both of these. On the one hand they are directed toward objects or goals, in that they constitute criteria or standards for the choice of such objects or goals. On the other hand, they are expressions of wants, interests, desires, and needs; that is, they are preferences. But in addition to being expressions of these characteristics, they are also expressed by them. In a sense, then, values affect our perceptions, and thus our wants and desires. Values then are standards, or criteria, which are non-objective, in the sense that they represent preferences, which are in part socially or culturally determined.

Secondly, values have a connotation of "right," or "should"—they represent the desirable. As Kluckhohn phrases it, "value implies a code or standard, which has some persistence through time, or put more broadly, which organizes a system of action. Values, conveniently and in accordance with received usage, place things, acts, ways of behaving, goals of action on the approval-disapproval continuum" (17, p. 395). Values are thus related to attitudes and opinions, as well as to interests and preferences.

HOW VALUES AFFECT COUNSELING AND PSYCHOTHERAPY

It was suggested above that values cannot be avoided in counseling and psychotherapy. Many of the client's problems involve values and value conflicts (2, 10). But there are other ways in which values affect the therapeutic relationship which should be considered in addition to their entering into the content of counseling or psychotherapy.

PHILOSOPHY OF COUNSELING

A philosophy is an integration or system of values, usually resulting in statements of postulates and assumptions, or principles.

It is only natural, and to be expected, that philosophies of counseling and psychotherapy should reflect the philosophies of the societies in which these activities operate. The prevailing philosophy of our society is a democratic one. This is more than a political term, although Meehl and McClosky (21) would make it primarily such. Democratic principles and values have permeated our economic, social, educational, and occupational institutions and relationships. And as Sutich points out, "It is evident that modern therapeutic and analytical principles have their roots in democratic principles. And it is equally evident that most American psychologists are committed to the support of democratic principles throughout the entire range of human behavior" (41). (In Chapter 6 we shall see that this is not universally true.)

What are the democratic principles which are accepted by counselors and psychotherapists? Bixler and Seeman (4), in their discussion of counseling ethics, present the postulates of Hand (12), which succinctly express these principles:

1. The belief that human life, happiness, and well-being are to be valued above all else.
2. The assertion that man is master of his own destiny, with the right to control it in his own interests in his own way.
3. The determination that the dignity and worth of each person shall be respected at all times and under all conditions.
4. The assumption of the right of individual freedom; the recognition of the right of each person to think his own thoughts and speak his own mind.

The philosophy of the client-centered approach to counseling appears to many counselors to be an expression of this democratic philosophy in the counseling relationship. Rogers (30, p. 5), speaking of the development of client-centered therapy, writes that "some of its roots stretch out . . . into the educational and political philosophy which is at the heart of our American culture." Green (10) feels that client-centered therapy is supported by the "democratic-liberalistic ideology."

The philosophy of client-centered counseling is expressed in the attitudes which the client-centered counselor holds and expresses toward his clients. These basic attitudes may be stated simply. The client-centered approach to counseling and psychotherapy is based on the following attitudes toward others, whether as clients or persons in other relationships with the counselor:

1. Each person is a person of worth in himself, and is therefore to be respected as such.
2. Each individual has the right to self-direction, to choose or select his own values and goals, to make his own decisions.

These, as simple as they seem, express the philosophy of client-centered counseling. These attitudes would probably be accepted by most counselors today, although the extent to which they are

implemented in counseling varies tremendously. The methods of implementing them will be discussed later.

VALUES AND COUNSELING ETHICS

Ethics are in a sense the specifics of a philosophy. It should be apparent from the discussion of the definition of values that values and ethics are related. The ethics of individuals and groups reflect their values. In fact, ethics might be considered as an expression or formalization of a group's values, an attempt to represent or express them in a systematized form. This is no doubt why Sutich (41) became involved in values in his discussion of ethics. Bixler and Seeman (4) state that "ethics are principles of action based on a commonly accepted system of values," thus relating professional ethics to social values. The APA code of ethics states that a cardinal obligation of the psychologist "is to respect the integrity and protect the welfare of the person with whom he is working" (1, p. 49). This is clearly an expression of the value of the individual in our society, as is recognized in Principle 1.13: "The psychologist should express in his professional behavior a firm commitment to those values which lie at the foundation of a democratic society, such as freedom of speech, freedom of research, and respect for the integrity of the individual" (1, p. 10).

The dependence of ethics on society is expressed by Newman (27), who states that codes of ethics "are quite meaningless unless they reflect, on the one hand, a set of social attitudes that are characteristic of the profession, and, on the other hand, attitudes possessed by the society that trusts and respects the profession."

VALUES AND THE GOALS OF COUNSELING AND PSYCHOTHERAPY

Goals reflect values, and therapeutic goals are no exception. The therapist has goals, either specific or general, and these are influenced by his values. "Values determine his concepts of mental health, his goals and aims" (2). Since no complete cure is possible, according to most therapists, what constitutes "tolerable

conflict" is a matter of the therapist's values (8). Ginsburg (8) states that "analysts must work with a definition of what constitutes the mental and emotional health they are trying to enable the patient to achieve; that such a definition must reflect the analyst's own values seems self-evident."

Concepts of mental health vary (34). Adjustment has often been conceived as the goal of counseling and psychotherapy. However, there has been increasing dissatisfaction with this concept. The question must be raised, "adjustment to what?" It is evident that adjustment to certain situations is undesirable. Moreover, if everyone were adjusted, change and progress would cease. Lindner (19) has been active in objecting to adjustment as the goal of therapy. Therapeutic progress or even success can be achieved while the client remains unadjusted to his environment, or to some aspects of it. The concept of adjustment is static. It leads to a subjective interpretation, influenced by the bias of the evaluator, or to a mass statistical interpretation, based on a definition of adjustment as nondisturbing behavior. De Grazia's (5, p. 146) illustration of the majority-vote concept of adjustment is pertinent here. He refers to the remark of Nathaniel Lee, the English dramatist, on being confined to Bedlam insane asylum: "The world and I differed as to my being mad, and I was outvoted." Moreover, adjustment to a small or deviant subgroup, e.g., of criminals or addicts, is not evidence of mental health.

Integration is another concept applied to the goals of psychotherapy. This concept stresses the internal state of the client, rather than his adjustment to a particular environment. But, presumably an individual can be integrated as a person while at the same time he is in conflict with his environment; and it has been pointed out that a paranoid may be integrated, yet is not mentally healthy.

Realizing the inadequacy of adjustment and integration, alone or in combination, as criteria of mental health, Jahoda (14, 15) and Smith (38) have added a third, which they call "cognitive

adequacy," or the perceptual adequacy for testing reality, thus proposing a triple criterion. Jahoda (14, p. 213), recognizing that "there exists no psychologically meaningful and, from the point of view of research, operationally useful description of what is commonly understood to constitute mental health," examined five criteria: absence of mental disorder or symptoms, normality of behavior, adjustment to the environment, unity of the personality, and the correct perception of reality. The first two were discarded, since symptoms are normal or abnormal depending on the cultural context, and it is difficult to define what is normal. Also, recognizing that "not every form of adjustment is a positive indication of mental health," and that adjustment may be "passive acceptance of social conditions to the detriment of . . . mental health," she proposes a criterion of active adjustment, or "mastery of the environment, involving a choice of what one adjusts to, and a deliberate modification of environmental conditions" (14, p. 216). Integration, or self-consistency, is not acceptable alone, since it doesn't imply freedom from conflicts with the environment. Correct perception of reality, both of the world and of oneself, while difficult to establish, since the majority judgment is not necessarily correct, is still useful as a criterion. No one criterion is adequate by itself.

While it is thus difficult to define mental health, counselors and psychotherapists have stated various goals of psychotherapy (16). Adjustment, integration, and an adequate perception of reality usually are included in these goals. One of the most extensive lists of the goals of therapy is that of Maslow (20, ch. 12) in his study of the characteristics of normal, healthy, "self-actualizing people." These characteristics are as follows:

1. More efficient perception of reality and more comfortable relations with it.
2. Acceptance of self and others, and of nature.
3. Spontaneity.
4. Problem-centered rather than ego-centered.
5. Able to be detached from turmoil, to rise above misfortunes.

6. Independence of culture and physical environment.
7. Freshness of appreciation.
8. A mystic experience.
9. Gemeinschaftsgefühl—sympathy and identification with others.
10. Deep interpersonal relations.
11. Democratic character structure.
12. Discrimination between means and ends.
13. Philosophical sense of humor.
14. Creativeness.
15. Resistance to enculturation.

This list includes most of the goals mentioned by other authors (16). No doubt it could be reduced by combination of characteristics. Many of them could be included under the concept of active adjustment or mastery of the environment, others under an accurate perception of reality, and others under integration. These characteristics are similar to the outcomes of client-centered therapy described by Rogers and others. Included is the goal of adequate interpersonal relations stressed by Sullivan, who writes that "One achieves mental health to the extent that one becomes aware of one's interpersonal relations" (40, p. 102). He states that "the processes of psychiatric cure include the maturation of personality, that is, the evolution of capacity for adult interpersonal relations" (40, p. 103). Improvement in mental health includes the development of the ability to relate with persons in terms of their present actual conduct, the acquisition of a realistic role-taking ability. The individual is less prone to project his hostilities, suspicions, and dependencies onto others. While certain attitudes toward others may be irrational, or emotional—of unknown origin—the individual accepts responsibility for them on a mature level.

There has been concern on the part of some regarding such goals as independence, spontaneity, and self-actualization. These goals seem to emphasize the individual to the detriment of society, and to encourage antisocial or asocial behavior. Such fears were felt with regard to sexual expression as a result of psychoanalysis.

Mowrer (22, 23) has criticized psychoanalysis for its emphasis on freeing the id from the rule of the superego, and implies that psychotherapy should strengthen the superego. Actually, self-actualization depends on other people. As we shall see later (Chapter 7), the individual is dependent on the esteem and regard of others for his own self-esteem. He is thus dependent on satisfactory interpersonal relations. This means that mature, responsible behavior is essential. In the goals listed above there is this concept of responsibility, as well as independence. Mowrer (22, 23) has used this concept of responsibility. Shoben (36) has suggested the "development of responsible individuals capable of maintaining and advancing a democratic society" as the goal of student personnel work, involving the "dual commitment to the worth of the individual and the furtherance of democracy."

The goal of psychotherapy might well be thought of as the development of a *responsible independence*. Counseling and psychotherapy thus would attempt to facilitate the development of individual independence in a client who takes responsibility for himself, his behavior, his choices and decisions, and his values and goals. This would be consistent with the democratic concept of the freedom of the individual, and also with the concept of the responsibility which accompanies freedom. Such a goal is clearly an expression of the values of a democratic society.

Responsible independence is perhaps an external definition of mental health. From an internal point of view self-actualization perhaps is an expression of the same concept. But a more general and universal or inclusive term is self-esteem. Self-esteem seems to be the essential quality of mental health, and its absence the distinguishing characteristic of mental disturbance. It perhaps is the sum or result of the concepts discussed above—active adjustment, integration, cognitive adequacy, responsible independence. Or possibly it can be looked upon as the antecedent or requirement for some of these, and for self-actualization, spontaneity, creative-

ness, etc. At any rate, self-esteem seems to be the key concept in mental health; it will be referred to frequently in later discussions.¹

There may seem to be the possibility of a conflict between the attitudes and goals of the counselor and the desires or wishes of the client. The client may not want to take responsibility for himself, to be independent. Clients frequently want immediate practical help on a current pressing problem, rather than to develop the capacity to handle their own problems. They desire relief for their symptoms rather than an understanding of themselves. Should the counselor be committed, as Meehl and McClosky (21) state, "to help the client achieve the client's end," whatever it is? Most counselors would say no. Almost every therapist, not only the client-centered counselor, is prepared "to thwart the momentary motivations of his client, apparently in terms of long-time goals, which are assumed to be mutually acceptable" (21). The counselor's ethics, values, and philosophy determine his goals in counseling, and he should not be required to compromise these. The client who does not wish to work under these conditions is not compelled to do so. He has the freedom to accept or reject any counselor and his services. To the charge that the counselor is putting himself in the position of thinking he knows best what the goals of counseling should be, the answer can only be one of "guilty"—the counselor must be free to choose his own goals for the counseling process. Actually, counselors and therapists have always done so. Psychoanalysts have insisted on the goal of personality reorganization as opposed to symptom relief. And they have sometimes been insistent on rather specific goals. Ginsburg (8) mentions an analyst who was dissatisfied with a patient at the

¹ For a recent detailed consideration of mental health, see Marie Jahoda, *Current concepts of positive mental health*. New York: Basic Books, 1958 (Monogr. Ser. No. 2, Joint Commission on Mental Illness and Health). The striking similarity between the concept developed here and Jahoda's conclusions from a study of the literature is apparent from the following quotation from Jahoda: ". . . one value strikes us as being compatible with almost all of the mental health concepts discussed here: an individual should be able to stand on his own two feet without making undue demands or impositions on others" (p. 80).

end of analysis because she still attended church. Church attendance was not a value to him—in fact a goal of this particular analysis was the severing of religious ties. Contrasted with this is the goal of Jungian analysts, who often encourage the return of the patient to religion. Although it may smack of “teacher knows best,” the client-centered counselor operates on the assumption that the client really needs and wants to develop a state or feeling of self-esteem, responsible independence, etc.; so that in reality the goals of the client, though he may be unaware of them, are the same as those of the counselor. (See Chapter 7 for further consideration of the basic need of individuals.)

THERAPEUTIC METHODS

It should be obvious that if values influence, or even determine, the goals of therapy, they also influence methods and techniques—the implementations of values—and means toward the goals. The APA code of ethics recognizes that “the psychologist’s ethical standards and his professional techniques are inseparable” (1, p. 37). Methods and techniques will be dealt with in more detail in another chapter. It is sufficient here to point out their relationship to therapeutic goals. Techniques are not chosen primarily on the pragmatic basis of whether they do or do not provide relief to the client, but in terms of their appropriateness to the ultimate goal of therapy. Respect for or unconditional acceptance of the client is a basis for the development of self-esteem. If this goal includes client responsibility and independence, then it would appear to follow that all techniques should be consistent with this goal. The client learns responsibility by practicing it, and this should begin in psychotherapy, not at its conclusion. The analysts’ practice of inducing a dependent transference relationship, which then must be resolved, appears to contradict this principle. Some have felt that this method prolongs therapy unnecessarily. That the transference neurosis is necessary has not been demonstrated; and the fact that profound reorganization of personality has taken place

in therapy without the development and resolution of a transference neurosis would indicate that it is not necessary. (See Chapter 9 for a discussion of transference.)

The counselor's values affect other aspects of the therapeutic relationship also. Ginsburg (8) points out that the role of values in the occupational choice of psychotherapy is a neglected area. He was referring to the monetary values of the practice of psychotherapy. Although the value or goal of earning a good living must not be denied, most people going into counseling or psychotherapy do so out of a desire to help others. This desire represents, in the mentally healthy individual, a value; and it influences the nature of the counseling relationship. Values also enter into the selection of patients or clients, as Ginsburg points out (8).

INFLUENCE OF THE COUNSELOR'S VALUES ON THE CLIENT

We indicated at the beginning of this chapter that the generally accepted point of view has been that the counselor's values should be kept out of the counseling relationship. In addition to Wilder, who was quoted, others have stressed this avoidance of influencing the values of the client. Deutsch and Murphy stress that "The therapist should by all means avoid impressing his own philosophy on a patient" (6, p. 17). Therapists have been exhorted to become aware of their own value systems, and those of the society and culture in which they work, to better avoid impressing them upon the patient. Most therapists have stressed the importance of allowing the client to develop his own value system (e.g., 47). Some have insisted that the client's value system cannot be influenced by psychotherapy, or that only those values which are consistent with his existing value system will be accepted by the client (28).

Is it possible for the therapist to avoid influencing his client? Can he actually prevent such influence? There is growing opinion, and some evidence, that he cannot. Ingham and Love express this conviction:

The existence of the therapeutic relationship puts the therapist in a posi-

tion in which he does, without choice, influence values in the mind of the patient. It is almost impossible for a therapist to avoid giving some impression of whether he favors such things as general law and order, personal self-development, and emotional maturity. The development of the relationship partly depends on the expression of such standards, because if the therapist were able to withdraw to such an extent that no evaluative attitudes would be apparent, he would not be able to participate sufficiently. But in an area in which the therapist does avoid revealing his ideas, the patient will project some onto him. So even if he could keep complete silence, he would still represent judgmental attitudes in the mind of the patient. If they have discussed an issue that involves moral values for a period of time, it is evident that the patient will have a concept of what the therapist thinks. His attitudes about right and wrong, or good and bad, are likely to be particularly influential for the patient (13, pp. 75-76).

Wolberg, commenting on Ginsburg's paper, states that "No matter how passive the therapist may believe himself to be, and no matter how objective he remains in an attempt to permit the patient to develop his own sense of values, there is an inevitable incorporation within the patient of a new superego patterned after the character of the therapist as he is perceived by the patient. There is almost inevitably an acceptance by the patient of many of the values of the therapist as they are communicated in the interpretation or through direct suggestion, or as they are deduced by the patient from his association with the therapist" (9). Parloff states that "The disclosure of many of the therapist's values is inevitable . . . such disclosure and communication may occur without the therapist being aware of it" (28). It might be expected that the therapist, by reason of his position and prestige, would become an example to the client, and that the client would tend to imitate him, intentionally or unintentionally, in terms of his perception of the therapist. As Parloff writes, "By virtue of the role of healer and model of mental health that the patient assigns to the therapist, every comment and action of the therapist is given great weight. The patient willingly or unwillingly becomes an avid student of what is pleasing and displeasing to the therapist" (28). The APA statement quoted earlier continues by saying

that "the attitudes, values, and ethical concepts of the psychologist are expressed in his clinical relationships and very directly influence the directions taken by his client" (1, p. 37).

There is some evidence that what these writers claim happens actually does happen. Rosenthal (32) studied 12 patients presenting a wide variety of diagnoses, and ranging in age from 18 to 46, who had from three weeks to one year of psychotherapy. Early in therapy they were given a test of moral values, along with other tests, including the Allport-Vernon-Lindzey Scale of Values. The therapists, who were psychiatric residents, were also given these two tests. The patients repeated the tests at the conclusion of treatment. The moral values test included items concerning sex, aggression, and authority. It was found that, in general, patients' scores on the moral values test changed during therapy, with those patients rated (by independent judges) as improved becoming more like their therapists, while those rated as unimproved tended to become less like their therapists.

In another study, Parloff and his associates (29) had observers list topics discussed during therapy by two schizophrenic patients. Every day, after the therapy hour, the patients and the therapist ranked these topics from most to least important. After therapy had been in progress for nine months, therapist and patients predicted each other's ratings. At the beginning of therapy, the values (as indicated by their ranking of topics) of both patients differed from those of the therapist. As therapy progressed, the patients' values came closer to those of the therapist, although for one patient no closer convergence occurred after the first six weeks of treatment.

There is some clinical evidence that the therapist influences the patient's values without attempting to do so or being aware of it. Parloff refers to the well-known fact that patients conform in their verbalizations to the terminology and theories of the therapist. If therapists value dreams, patients dream; if the therapists value sexual material, patients produce it, etc. "The literature is replete

with examples of patients unwittingly adapting their productions and even use of symbols to the particular psychodynamic theories and preferences of their therapist" (28).

One mechanism of such influence is suggested by some interesting experiments of Greenspoon (11) and Verplanck (44, 45). In these studies it was found possible to control the subjects' verbal behavior by means of operant conditioning, without awareness on the part of the subjects. In the case of psychotherapy, it is easy to imagine the effect on the client of such responses of the therapist to the patient's verbalization as a trace of a smile or a pleased look, an incipient nod of the head, or other mannerisms indicating his attitude, favorable or unfavorable, toward the patient's productions—all of which may be unknown to the therapist and the patient. Parloff (28) presents some evidence that the therapist's responses may be classed by observers as "approving" or "disapproving," and that these responses were related to the therapist's ranking of the topics responded to in terms of their importance. This occurred without the therapist being aware of the differential nature of his responses as "approving" or "disapproving." It was also found that the frequency with which the patient introduced a topic was related to the type of the therapist's response.

INTENTIONAL INFLUENCE OF THE CLIENT'S VALUES

As indicated above, it has been generally agreed that the therapist should not consciously attempt to manipulate the patient's values. Recently, however, there have been what Wilder (in 9) refers to as "rising voices to the effect that the analyst not only does but should transmit his own value system to the patient." He writes: "A patient often says 'Doctor, after all, you seem to have found a measure of peace and stability, why don't you shorten the therapy by simply telling me your philosophy?' " Taylor (42), in a letter to the editor, taking issue with the writer of an article making a plea for the abandonment of direction or guidance in counseling, suggests that there are common, general patterns of

human conduct which are ethically "good," and that counselors are justified in introducing them in guidance. Weisskopf-Joelson (48) proposes that the inculcation of a philosophy of life be considered as one of the objectives of psychotherapy. Thorne (43) includes reëducation in a philosophy of life as a method of counseling.

Gardner Murphy (25) has recently asked: "Shall personnel and guidance work . . . attempt to impart a philosophy of life?" While admitting that "no one knows enough to construct an adequate philosophy of life," he says that "nevertheless if he who offers guidance is a whole person, with real roots in human culture, he cannot help conveying directly or indirectly to every client what he himself sees and feels, and the perspective in which his own life is lived." He then suggests that "it is not true that the wise man's sharing of a philosophy of life is an arrogant imposition upon a defenseless client." To the argument that all philosophies are subjective, arbitrary, or relative, he points out that nevertheless counselors are influenced by a philosophy in choosing their work. He feels that the young need help and advice from those who have thought things through. But he warns counselors not to "attempt the arrogant and self-defeating task of guiding men and women without a rich, flexible, and ever-growing system of values of your own."

Wrenn (51) writes that the counselor "may or may not . . . assist the client in an understanding of life purposes and meanings, and the alternate ways in which one may relate oneself to the Infinite."

There is some slight evidence, in the studies of Rosenthal and Parloff (32, 28, 29) that those clients who improved, or improved most, tended to approach most closely to their therapists in values. This, if true and borne out by other studies, might appear to be an argument for direct intervention toward influencing the values and philosophies of clients. However, it must be remembered that this result occurred in therapy where apparently no overt or direct

attempt was made to influence the client. It might not hold where direct influence was attempted. Indeed, every counselor well knows the resistance that often develops where direct influence is attempted, and the resistance that often follows the attempt to fulfill a direct request of the client for advice or other help.

Granted that the counselor will influence the client, whether he desires or directly attempts to do so, is it therefore justifiable to attempt direct manipulation? Probably not, for a number of reasons.

First of all, while there are no doubt some generally, or even almost universally, accepted principles or ethical rules, these do not constitute a philosophy of life. Each individual's philosophy is different, unique, and something which is probably not adequate for any other individual. One may even question how much agreement there is on ethical principles or rules of behavior. De Grazia cites many illustrations of varying and contradictory or conflicting moral directives given by different therapists (5, pp. 152-155). The only universally proscribed behaviors appear to be the killing of members of one's own group, incest, and possibly betrayal of the group.²

Second, it is too much to expect all counselors to have a fully developed, adequate philosophy of life ready to be impressed on the client. All counselors are not, to use Murphy's term, wise men.

Third, the counseling relationship is not the appropriate place for instruction in ethics and a philosophy of life. The home, church, and school are more appropriate sources for such instruction.

Fourth, an individual does not develop a system or code of ethics, or a philosophy of life, from one source, or in a short interval of time. These are the products of a long period of time and many influences.

² The existence of infanticide and cannibalism (though the latter usually is not practiced upon members of one's own group), and the intermarriage among royal families, raise a question whether even these are universally proscribed behaviors.

Fifth, it would appear to be best for each individual to develop his own unique philosophy, and not to be deprived of the experience of doing so. Such a philosophy will probably be more meaningful and effective than one adopted from someone else, no matter how wise a man he be. It cannot be imposed from without, but must be developed from within.

Sixth, we must still accept the right of the client to refuse to accept any system of ethics, or any philosophy of life.

This does not mean that the counselor refuses to discuss ethics, values, or philosophy. It does not mean that he is not concerned about the influence he has on the client in these areas. He recognizes this, and attempts to be a constructive influence, but not by attempting to manipulate the client in the counseling process. He does it by being himself. As Murphy (25) suggests, "A great deal of what you communicate to your client is not what you say but what you are." Further than this, the counselor on some occasions must express his own values. He may do so on the request of the client. But he carefully identifies these expressions as his own, and avoids imposing them on the client, or implying that the client ought to feel the same way.

There may also be times when the counselor, whether by request of the client or not, feels it necessary or desirable to inform the client of the attitudes, standards, or values of society, or the ordinary or generally accepted rules of ethics and morality. In a more or less rational problem-solving type of counseling, for example, where there is lack of information on the part of the client, the counselor may attempt to supply this lack (49).

The counselor should not strive to be an amoral, ethically neutral individual. Such a goal would be impossible of achievement—all of us have values, merely by being living human beings. Nor should the counselor attempt to pretend that he is amoral. It is unlikely that he could successfully give this impression to his clients, but it is also undesirable that the counselor attempt to appear to be other than he actually is. Furthermore, the attempt to

appear to be neutral as regards social and ethical standards may lead to the danger of appearing not only to accept the client's unethical or immoral behavior, but of approving or condoning it. Counselors are not indifferent to social and moral standards, and should not attempt to appear to be so. On the other hand, the counselor should not judge or condemn the client because of his behavior or actions. Nor should he exhort or attempt to persuade the client to accept his (the counselor's) or any other specific standards or rules of living.

Biestek (3) presents an excellent discussion of the behavior of the counselor in the area of ethics and standards. He points out that while the counselor may judge the attitudes, standards, or actions of the client in terms of his own or prevailing standards, he does not judge the client himself. He further states that "this judgment is preferably made non-verbally; the client usually is able to make such appraisals of himself in the security of an accepting relationship." He suggests that the counselor cannot be indifferent to social, legal or moral wrong, and must favor the good. "This attitude, even if unexpressed, will be felt intuitively by the client; it serves as a source of strength and support for him. . . . In the non-judgmental attitude the [counselor] does not relinquish his own sense of values, his personal and social ethics. He cannot remain interiorly indifferent to standards contrary to his own if he is to maintain the integrity of his own personality. He must remain true to them. He does not become moralistic, but he has a right to his own sense of social, moral, and spiritual values, personally and professionally" (3).

Ingham and Love give two reasons for avoiding indoctrination of moral standards: "The first, and most important, is that the therapist might succeed. And no human being is entirely safe in trying to impress his concepts of right and wrong on another, who has a different personality and background. . . . The second reason is that the therapist might fail. And trying to impress moral values in psychotherapy without success interferes with the free-

dom of the participants' communication and the strength of their relationship" (13, p. 77).

The above point of view may appear to be a departure from the client-centered framework. Like many other therapists, the client-centered counselor has professed neutrality, and has felt in many cases that he has achieved it. Actually, he has perhaps been no more successful than have other therapists. De Grazia (5, pp. 152-158) gives examples of the expression of counselor moral attitudes and values from published typescripts of client-centered interviews.

The proposal that the counselor not only should be aware of and has a right to his own moral attitudes and values, but should sometimes express them in the counseling relationship, is consistent with recent developments in client-centered thinking. Stressing that the therapist should be himself in this relationship with the client, Rogers (31) suggests that the therapist should express his own feelings as he experiences them. (See Chapter 9 for further discussion of counselor expression of his own feelings.)

The approach to values in counseling as outlined in this chapter appears to have several advantages. By recognizing that the counselor's moral attitudes and values do enter into counseling, it prevents the counselor from erroneously believing that he is neutral. Freed from this belief, and the feeling that it is necessary or desirable to be neutral, the counselor is better able to recognize and accept his own values. He then can be aware of them in the counseling relationship; and, when he feels that the counseling relationship would be improved or furthered by his expressing his own attitudes and feelings, he can do so. That is, he can freely be himself, without guilt about doing so, or without feeling that he should not have any feelings. Finally, this approach contributes to the openness of the counseling relationship, without violating its client-centeredness. In fact, the relationship is probably more client-centered. That is, where the counselor's attitudes and feel-

ings are unexpressed, even unrecognized by the counselor, they may, and apparently do, have a pressuring influence on the client. Where they are expressed by the counselor and labeled as representing his own values, feelings, attitudes or point of view, or identified as those of others, or society in general, there is less coerciveness about them. While there are some who would sanction the counselor acting as a representative of society in prescribing moral or ethical values or standards (5), the majority of therapies, including client-centered therapy, still insist that the client must freely accept or reject such values, and develop or construct his own ethical system or philosophy of life. Some apparently fear that the client when given such freedom will choose wrongly or adopt an unethical or immoral course of behavior. The client-centered counselor, while not condoning a wrong choice, would respect the client's right to make it. He would feel that the counseling relationship is not the place to teach moral or ethical standards, or a philosophy of life. He is confident, as apparently some are not, that the client in the therapeutic relationship will be aware of and influenced by social realities. He will leave to the family, the church, and the school, as institutions representing the moral and ethical standards of society, the teaching of such standards.

While the therapist does not teach or impose specific values or a philosophy of life, it should be clear that he does implement in his therapy a philosophy of counseling which in effect is his philosophy of life. His goals, his methods and techniques, and his ethics all express this basic philosophy. No therapist can avoid this. The approach to counseling and psychotherapy outlined in this book is no exception. This approach explicitly accepts and practices a philosophy, or a value system. The essence of this system is the recognition of the value of the individual, his dignity and worth, and his freedom or self-determination in regard to his choices and life goals. In so far as the expression of these values in the therapeutic relationship through the therapist's behavior to

the client is an example, the therapist is "teaching," or perhaps imposing his values on the client. The therapist has no choice in this, since all behavior—all goals and methods of therapy—are expressions of the therapist's values. The client is, however, free to accept or reject them, to continue therapy or to choose another therapist. The client who continues therapy is accepting the values which the therapist practices, including the goals of his approach to psychotherapy. These are the democratic, humanitarian values inherent in good human relationships, and thus of good mental health.

REFERENCES

1. American Psychological Association. *Ethical standards of psychologists*. Washington: Author, 1953.
2. Bergum, Mildred. Values and some technical problems in psychotherapy. *Amer. J. Orthopsychiat.*, 1957, 27:338-348.
3. Biestek, F. P. The non-judgmental attitude. *Social Casework*, 1953, 34:235-239.
4. Bixler, R. H., & Seeman, J. Suggestions for a code of ethics for consulting psychologists. *J. abnorm. soc. Psychol.*, 1946, 41:486-490.
5. De Grazia, S. *Errors of psychotherapy*. Garden City, New York: Doubleday, 1952.
6. Deutsch, F., & Murphy, W. F. *The clinical interview*. New York: International Universities Press, 1955.
7. Ginsburg, S. W. Psychiatry and the social order. *Ment. Hyg.*, 1948, 32:392-406.
8. Ginsburg, S. W. Values of the psychiatrist. *Amer. J. Orthopsychiat.*, 1950, 20:466-478.
9. Ginsburg, S. W., & Herma, J. L. Values and their relationship to psychiatric principles and practice. *Amer. J. Psychother.*, 1953, 7:546-573.
10. Green, A. W. Social values and psychotherapy. *J. Pers.*, 1946, 14:199-228.
11. Greenspoon, J. The reinforcing effect of two spoken sounds on the frequency of two responses. *Amer. J. Psychol.*, 1955, 68:409-416. (Abstract.)
12. Hand, H. C. America must have generally democratic high schools. In *General education in the American High School*. Chicago: Scott Foresman, 1942. Ch. 1.
13. Ingham, H. V., & Love, Leonore R. *The process of psychotherapy*. New York: McGraw-Hill, 1954.

14. Jahoda, Marie. Toward a social psychology of mental health. In M. J. E. Senn (Ed.), *Symposium on the healthy personality. Supplement II: Problems of infancy and childhood*. New York: Josiah Macy Foundation, 1950.
15. Jahoda, Marie. The meaning of psychological health. *Social Casework*, 1953, 34:349-354.
16. Kelman, H., et al. Goals in therapy: a round table discussion. *Amer. J. Psychoanal.*, 1956, 16:3-23.
17. Kluckhohn, C., et al. Values and value orientations in the theory of action. In T. Parsons & E. A. Shils (Eds.), *Toward a general theory of action*. Cambridge: Harvard University Press, 1952.
18. Lee, A. McC. Social pressures and the values of psychologists. *Amer. Psychologist*, 1954, 9:516-522.
19. Lindner, R. *Prescription for rebellion*. New York: Rhinehart, 1952.
20. Maslow, A. H. *Motivation and personality*. New York: Harper, 1954.
21. Meehl, P. E., & McClosky, H. Ethical and political aspects of applied psychology. *J. abnorm. soc. Psychol.*, 1947, 42:91-98.
22. Mowrer, O. H. Motivation and neurosis. In J. S. Brown et al., *Current theory and research in motivation*. Lincoln, Nebraska: University of Nebraska Press, 1953.
23. Mowrer, O. H. Some philosophical problems in mental disorder and its treatment. *Harvard educ. Rev.*, 1953, 23:117-127.
24. Murphy, G. *Personality: a biosocial approach to origins and structures*. New York: Harper, 1947.
25. Murphy, G. The cultural context of guidance. *Personal Guid. J.*, 1955, 34:4-9.
26. Murphy, G., Murphy, Lois B., & Newcomb, T. M. *Experimental social psychology*. (Rev. ed.) New York: Harper, 1937.
27. Newman, E. B. Public relations—for what. *Amer. Psychologist*, 1957, 12:509-514.
28. Parloff, M. B. Communication of values and therapeutic change. Paper read at symposium on "Evaluation of Process and Results of Therapies: I. General Problems of Methods and Theory." American Psychological Association, New York, August 31, 1957.
29. Parloff, M. B. Iftund, B., & Goldstein, N. Communication of "therapy values" between therapist and schizophrenic patients. Paper read at American Psychiatric Association annual meeting, Chicago, Illinois, May 13-17, 1957.
30. Rogers, C. R. *Client-centered therapy*. Boston: Houghton Mifflin, 1951.
31. Rogers, C. R. *A theory of therapy, personality, and interpersonal relationships, as developed in the client-centered framework*. Chicago: Author, 1956. (Mimeographed.)

32. Rosenthal, D. Changes in some moral values following psychotherapy. *J. consult. Psychol.*, 1955, 19:431-436.
33. Sargent, Helen. Professional ethics and problems of psychotherapy. *J. abnorm. soc. Psychol.*, 1945, 40:47-60.
34. Scott, W. A. Research definitions of mental health and mental illness. *Psychol. Bull.*, 1958, 55:29-45.
35. Seeley, J. R. Guidance: A plea for abandonment. *Personnel Guid. J.*, 1956, 34:528-535.
36. Shoben, E. J., Jr. New frontiers in theory. *Personnel Guid. J.*, 1953, 32:80-83.
37. Shoben, E. J., Jr. Toward a concept of the normal personality. *Amer. Psychologist*, 1957, 12:183-189.
38. Smith, M. B. Optima of mental health; a general frame of reference. *Psychiatry*, 1950, 13:503-510.
39. Smith, M. B. Toward scientific and professional responsibility. *Amer. Psychologist*, 1954, 9:513-516.
40. Sullivan, H. S. *Conceptions of modern psychiatry*. Washington: William Allanson White Psychiatric Foundation, 1947.
41. Sutich, A. Toward a professional code of ethics for counseling psychologists. *J. abnorm. soc. Psychol.*, 1944, 39:329-350.
42. Taylor, Charlotte P. Social and moral aspects of counseling. (Letter to the Editor.) *Personnel Guid. J.*, 1956, 35:180.
43. Thorne, F. C. *Principles of personality counseling*. Brandon, Vermont: Journal of Clinical Psychology, 1950.
44. Verplanck, W. S. The control of the content of conversation: reinforcement of statements of opinion. *J. abnorm. soc. Psychol.*, 1955, 51:668-676.
45. Verplanck, W. S. The operant conditioning of human motor behavior. *Psychol. Bull.*, 1956, 53:70-83.
46. Walker, D. E., & Peiffer, H. C. The goals of counseling. *J. counsel. Psychol.*, 1957, 4:204-209.
47. Weiss, F. Psychoanalysis and moral values. *Amer. J. Psychoanal.*, 1952, 12:39-49.
48. Weisskopf-Joelson, Edith. Some suggestions concerning Weltanschauung and psychotherapy. *J. abnorm. soc. Psychol.*, 1953, 48:601-604.
49. Williamson, E. G. Value orientations in counseling. *Personnel Guid. J.*, 1958, 36:520-528.
50. Wrenn, C. G. The ethics of counseling. *Educ. psychol. Measmt*, 1952, 12:161-177.
51. Wrenn, C. G. Psychology, religion, and values for the counselor. *Personnel Guid. J.*, 1958, 36:331-334.
52. Zilboorg, G. Clinical variants of moral values. *Amer. J. Psychiat.*, 1950, 106:744-747.

CHAPTER 5

Cultural Factors and Psychotherapy

In the last chapter the significance of values in counseling was outlined. It was pointed out that values are related to the society or culture in which the counselor and client live. The cultural factor is important in other ways in the counseling relationship. In this chapter we shall examine the nature of this influence.

Culture is important because it is a significant factor in the development of the personalities of both the client and counselor. Culture influences the nature of personality disturbance. Attitudes of the client toward counseling or treatment, and the attitudes and methods of treatment of the counselor or therapist are also affected by cultural factors.

CULTURE AND PERSONALITY

Interest in the relation between culture and personality has been growing in recent years. It is not, however, a new interest. Sociologists were concerned with this relationship early in this century. W. I. Thomas was perhaps the first to indicate the relationship of personality to culture (11). One of the earliest discussions is that of Cooley, who suggested that society and the individual are but two aspects of the same phenomenon or process (17). The thesis that it is only in the group that the individual organism develops a

personality is perhaps best delineated by George H. Mead (72). The definition of personality as the subjective aspect of culture (30) reflects the significance of the cultural factors in the minds of many sociologists. Faris (30) also defines personality as the organization of the various roles which an individual plays in society. This is similar to William James' concept of an individual as consisting of various selves representing the different roles which he plays. Since society defines these roles, the influence of culture is obvious. The individual, through the process of social learning as a member of a social group, absorbs and incorporates into himself the customs, traditions, values, and standards of his society, as well as the behavior appropriate for the various roles which he will play; and in the process of doing so he becomes a person, or develops a personality.

Following the early contributions of the theoretical sociologists, anthropologists became interested in the relation of personality to culture. Linton (68) was one of the first to discuss the problem in his book *The Study of Man*. He distinguished two aspects of personality, its content and its organization, and suggested that culture is responsible for the bulk of the content. He defined two levels of personality organization: a superficial organization including dominant interests and goals, and a central organization contributing the distinctive or individual character of the personality. Culture is responsible for much of the superficial organization, and probably for some of the central organization. In later writings Linton (69, 70) elaborated and changed his views somewhat. He developed the concept of a basic personality type consisting of an integrated configuration of common personality elements and resulting from the common experiences of all individuals in a society. Superimposed upon and integrated with this basic personality are status personalities. Status personalities develop on the basis of the roles which the individual occupies in the social system. Statuses are ascribed on the basis of age, sex, birth or marriage into particular family units, occupations, or social func-

tions, etc. Other anthropologists who have been concerned with this area are Mead (73, 74), Kluckhohn (62), and Honigmann (51), the last of whom has written perhaps the only text specifically concerned with culture and personality.

Sociologists and anthropologists have come to some general agreement on the relations between culture and personality. Every human being is born into a society. Since there are few if any true human instincts, the individual is shaped by his experiences. Some of these experiences are common to all men, and these, together with the common needs underlying them, result in the uniformities among all humans. These uniformities may be designated as human nature.

Besides this universally shared experience, every individual is subjected to other experiences in common with certain groups of individuals. The largest group is the society in which he lives. Societies continue to exist as societies by teaching their cultures to the individuals of each generation. Culture consists of the attitudes or feelings, ideas or thoughts, actions or behavior, and the material articles which are shared by the members of a society. Within a society, the individual is exposed to somewhat differing aspects or elements of the culture depending on the subgroups to which he belongs, including his age-sex class, his family position, and the social roles he plays or is destined to play in occupying the established statuses of the society. In a small, homogeneous society all members may have much in common, and participate in the basic personality type. In large, heterogeneous societies such as our own, it may be questioned whether enough is possessed in common, in terms of attitudes, ideas, and behavior, to warrant the designation of a basic personality type. On the other hand, it has been suggested that there may be developing a universal personality as men come to regard themselves as citizens of the world (10, p. 51).

Linton (68, p. 140) distinguishes two types of cultural influence. One is the culturally determined or patterned behavior toward the child. The other "derives from the individual's observa-

tion of, or instruction in, the patterns of behavior characteristic of his society." Others distinguish between direct, active, formal, or conscious learning, and indirect, latent, unconscious, absorptive, implicit learning, or what Plant (84) has termed psycho-osmosis.

The culture tends to integrate the individual into the society, so that there is a congruence and coherence of attitudes, thoughts, and behavior. The basic culture is learned early and, due to the primacy of habits learned in infancy, persists and resists change. This would appear to result in uniformity among the members of a society, or at least among the members of subgroups or statuses. Individual differences do, of course, arise, even though there is perhaps a mode from which deviations occur. Variations develop for several reasons. First, each individual is a distinct biological organism, different from anyone else, and reacting to stimuli slightly differently. Secondly, each individual is exposed to a slightly different form of the culture, which is filtered through and distorted by the individuals with whom he interacts. No two individuals have exactly the same environment, either physical or cultural. These two facts result in slightly different experiences for every individual from birth on. Later experiences are influenced by the earlier ones, so that greater variation is introduced by differing perceptions of the same situations in later life.

Criticism has been directed at much of the writing on culture and personality (56, 61, 67). There is little if any information in most studies about the number or sampling of the individuals studied in a culture. There is usually no distinction made between original data and interpretations made from it, often only the latter being published. Oversimplification, selectivity, and neglect or explaining away of negative evidence are common. Neglect of subgroup variations and of the influence of postinfancy experiences on the personality distort many studies. Attempts to correlate later personality with specific techniques of child rearing, e.g., swaddling and toilet training, have been particularly criticized. Inkeles states that "there is a widespread feeling on the part of many

critics that an adequate and necessary connection has not been established between such patterns of infant training and specific characteristics of adult behavior" (56, p. 580). There is increasing recognition that it is not specific techniques but the configuration in which they are manifested which is important (81, p. 59; 96, pp. 82-83).

Such criticism does not invalidate the basic fact of a close relationship between personality and culture, however. The relationship is so close that culture and personality, as Murphy (76) points out, are inseparable. Personality, he says, in effect, is an interaction, and this requires an environment. A complete definition of personality involves the cultural field, and "practically the entire cultural picture must be studied to say anything meaningful about the person" (76, p. 15). The reverse is also true, so that personality and culture are two aspects of one phenomenon. As Spiro (99) says, "The development of personality and the acquisition of culture are one and the same process." Personality, on the one hand, may be seen as the result of the interaction of the individual with his environment, both social and material. Culture, on the other hand, may be defined as the product of the interaction of individuals with their environments. We are apparently accepting the point of view of Cooley and Faris (17, 30) who earlier saw the individual (a person) and society as two aspects of the same thing. Faris, defining personality as the subjective aspect of culture, at the same time defined culture as the collective side of personality (30).

That culture is important in personality formation should not be a surprise to psychologists. All behavior has learned aspects. The anthropologists, by calling our attention to wide cultural differences, opened our eyes to the obvious, which had been concealed in our absorption with a single culture. The content of learning is supplied by the culture. We learn what we are exposed to, what we are taught, and this is limited and determined by our culture.

Anthropologists, on the other hand, have not been clear about

the process of acculturation. Sometimes the impression is given that the culture shapes the personality in some mysterious way. Psychology can assist anthropology in analyzing the process, and there is evidence that anthropologists are applying the findings of psychology to the study of acculturation. Honigmann (51) gives considerable attention to the learning process in his discussion of the field. The student who desires to pursue further some of the interesting problems in this area might begin with some of the references appended to this chapter including some not cited in the summary above (7, 20, 21, 42, 43, 44, 62, 64, 73, 74).

CULTURE AND EMOTIONAL DISTURBANCE

If culture molds personality, or if personality is an aspect of or a reflection of culture, then it must follow that personality disturbances or emotional disorders reflect the culture. There is an increasing amount of literature on this subject—written by sociologists, anthropologists, psychiatrists, and psychologists. We can do no more here than to refer to some of it.

While the sociologists were among the first to recognize the influence of the social environment on personality, the anthropologists were perhaps earlier in studying the relation of emotional disorders to culture. Benedict (9) stressed the relativity of behavior abnormalities, pointing out that individuals who are considered abnormal in one culture would function with ease or even honor in another culture. She writes that "Normality is culturally defined. It is primarily a term for the socially elaborated segment of behavior in any culture; and abnormality, a term for the segment that that particular civilization does not use." Other anthropologists became interested in the problems involved (18, 42, 51, 62, 68, 69, 70). Their writings suggest some of the cultural sources of personality disorder. Since the normal is what is approved, expected, and taught in a society, one might question how abnormal behavior arises. As Benedict indicates, even though there is a wide range of temperament (constitutional differences) in any society,

the vast majority of individuals are successfully molded to the culture. Yet there are some who fail to learn, whether because of individual resistance or failure of the methods of the culture. The abnormal person is then the "individual upon whom that culture has put more than the usual strain . . . adaptation involves a conflict in him that it does not in the so-called normal" (9).

In addition to the strain of the demands of society upon possibly susceptible individuals, there is another commonly mentioned source of disturbance in culture. This involves conflict within the society itself. Using Linton's concept of statuses requiring the assumption of related roles, there is the possibility of conflicts among the roles which an individual is required to play (69, pp. 80-82; 52, 53). These conflicts would be more likely to occur in a complex, heterogeneous society than in a simpler, more homogeneous one. There is some evidence that personality disorder is more prevalent in complex, heterogeneous societies than in more homogeneous ones (6, 24, 29, 81, 106).

Mead writes that "In a heterogeneous culture, individual life experiences differ so markedly from one another that almost every individual may find the existing cultural forms of expression inadequate to express his peculiar bent, and so be driven more and more into special forms of psychosomatic expression" (73, p. 72).

Beaglehole, however, feels that "in no way does it seem possible to draw any correlation, even the roughest, between the relative complexity or simplicity of a society and the incidence of major mental disorders" (5, p. 253). It is true that most contemporary so-called primitive societies are not simple or homogeneous but relatively complex. Mead (73) also recognizes that homogeneity does not mean the absence of disorder. The factor of stability as well as complexity is no doubt important. A society may be highly complex, yet stable, and therefore have a low rate of personality disturbance. It is conflict, rather than complexity *per se*, which is the significant factor, though the complex society may, other things

being equal, have more possibilities of conflict. Certainly complexity is not the only significant factor.

In a complex society each individual has many different roles, thus increasing the chances of conflict. Also, many of these roles require only a limited involvement of the individual, rather than his total personality. Membership in groups or subgroups whose values, standards, or practices are in conflict may be a source of conflict. Hunt (54) provides an example of this conflict.

In addition to conflicts among the present or contemporary demands or expectations of a society, there are the conflicts related to cultural change. In a rapidly changing society the individual is subjected to the stress of adapting to different or conflicting expectations during his lifetime; this is often a source of intrapersonal conflict (74, 104).

One must avoid the confusion of fixed symptoms with the presence of psychological abnormality, for as Benedict (9) points out, there are instances where behavior which is symptomatic of disorder in one society is normal or even highly valued in another. There are some who attempt to define behavior which is abnormal in any society, i.e., "culture free" symptoms—there are perhaps a few types of behavior which can be defined as universally abnormal. There is also socially deviant behavior which may not be abnormal or pathological (51), though Benedict (8) appears to accept these as synonymous. Not all deviant, or even abnormal, behavior is undesirable. As suggested in the last chapter, the personally or socially unadjusted individual may be the source of cultural and social change or progress (4). An extension of role conflict is the conflict induced in an individual who is exposed to more than one culture, the so-called "marginal man" of the sociologists. Such individuals, as well as immigrants, are exposed to conflicting standards or demands (8, 44, 54, 104).

Psychiatrists also have become interested in the influence of culture on personality disturbances. Kardiner (59, 60), influenced by the anthropologists, presents analyses of several cultures in

psychoanalytic terms. Plant (84) used child guidance clinic materials to investigate the relationship between personality and the cultural pattern. Among psychiatrists, those influenced by the interpersonal theory of Harry Stack Sullivan (75, 101) have perhaps been most aware of and concerned about the cultural influences on emotional disturbance. Mullahy, a Sullivanian, feels that mental illness is "a product of a social order which is in some ways grossly inadequate for the development of healthy and happy human beings" (75, p. xvii).

Horney (52, 53) has been a leading exponent of this approach. She has discussed the conflicting values and attitudes present in our contemporary American culture. These include conflicts between dependence and independence; aggression and submission; self-assertion and humility; coöperation and competition. Each value or attitude of a pair is endorsed by the culture, yet they are inconsistent with each other. In some cases there is a discrepancy between what is taught in childhood, in the home, the church, and the school, and what is expected or approved in adulthood. Honigsmann points out the discrepancy when "we demand submission in children and then expect them to manifest patterns of adult self-assertion or dominance. Children are first shorn of responsibility and later faced with the problem of acquiring an adult's sense of responsibility" (51, p. 81).

Benedict (9) earlier had pointed out that "The particular forms of behavior to which unstable individuals of any group are liable are many of them matters of cultural patterning like any other behavior." In other words, the content of a personality disturbance is culturally determined. Horney (52, p. vii) states that cultural conditions "not only lend weight and color to individual experiences but determine their patterns and particular forms." The question of whether the nature of personality disorders varies with cultural factors is not clear. Recent summaries of the nature and extent of mental disorder in primitive or nonliterate societies (6; 81; 106, pp. 153-156, 228-232, 255-258) do not resolve this issue,

though it does appear that while the relative and absolute frequencies may vary, every type of disorder is found in every society (18, 43, 81, 94). The variation of type of disorder with time is also not clear. There is evidence that the incidence of certain types of neuroses has decreased while that of others has increased. In Western industrial civilization, e.g., hysterical disorders appear to have decreased, while psychosomatic disorders have increased (81, pp. 82-86). Increase in the latter has resulted in peptic ulcer being considered an ordinary disease of modern businessmen in an urban competitive society. Whether this should be considered a new kind of disorder, or merely a different manifestation of the same basic neurosis, is not clear. The range of psychosomatic symptoms appears to be present in other cultures; so that again it is perhaps a matter of variability in rate or incidence rather than different kinds of disorder being characteristic of different cultures (96, p. 15).

Sociologists have been interested in the ecological and social distribution of personality disturbance (16; 106, pp. 153-156). Faris and Dunham pioneered this approach with their 1939 publication (33). They found that the incidence of mental disorder varies with the ecological or areal pattern of the city, it being high in areas of transition, high mobility, and lack of close interpersonal relationships, and low in the better residential areas farther from the center of the city. These results fit in with the above idea that a complex, changing culture is conducive to disorder.

Social disorganization, the loss of control of the mores over the members of the group, is not synonymous with personal disorganization. All but the most static groups experience some social disorganization in the process of change. But if change is rapid, and social disorganization widespread, personal disorganization increases. There is less possibility or opportunity for the development of an integrated individual system of attitudes, habits, and behavior. Freedom from social controls, which is increasingly characteristic of our modern society, requires the development of conscious, intelligent, individual self-control, without the support

of tradition and established mores. The difficulty of this leads to increased personal disorganization.

These observations also have led to the development of the cultural isolation theory of emotional disorder, specifically of schizophrenia, by some sociologists (26, 31). Others have questioned this theory. Clausen and Kohn (16, 63) did not find evidence for it in their study, nor did Jaco (57), nor Weinberg (105). Clausen and Kohn (16) ask: "Is isolation a symptom of already-developing illness; is it an essential condition for the subsequent development of illness; or is it, possibly, both symptomatic of the beginning of illness and a cause of its further development?"

Weinberg (105) suggests that isolation *per se* is not sufficient, but that it is the meaning of the isolation as it reflects upon the individual's self-esteem which is significant. He sees the process as one in which the individual (1) rejects his self-image, but seeks acceptance, both from himself and others; (2) is unable to communicate his conflicts, or has no one to whom to do so; (3) resorts to withdrawal as a means of self-protection. He bases this description of the process upon his study of "transient" and "reaction" type schizophrenics. He thinks that the transient schizophrenic resists or struggles against a lowered self-esteem, while the process schizophrenic accepts it. It is possible that the process schizophrenic goes through the same struggle, but earlier in life, and becomes isolated earlier or at a younger age.

There is some recent evidence that isolation can lead to personality disturbance. At McGill University, experiments carried out on normal subjects indicate that isolation from sensory stimuli results in symptoms of personality disturbance, including hallucinations and depersonalization (45). Sensory isolation of patients who had been receiving psychotherapy led to disorganization (3). Isolation is perhaps important as one means of breaking down communication with the outside world, particularly the social

world. It may also be a result of the loss, from other causes, such as defects in role-taking ability, of the capacity to communicate.

Weinberg includes two important concepts in his formulation. One is the defect in communication, and the other the loss of self-esteem. These factors are becoming increasingly recognized as significant in emotional disturbance (92, 101). Elsewhere, Weinberg (106, pp. 11-12, 193) defines disordered behavior as a breakdown in social learning resulting from obstructions in communication and social participation. Role-taking is the basis for communication; it is the ability to take the position of another, understand his point of view, and see oneself as others do. "The extent to which one has developed a capacity for role-taking indicates his degree of ordered behavior. The individual who can judge and respond to the actual attitudes of another person can also control and revise his conduct accordingly. His behavior is realistic because he responds to attitudes which actually exist in the other person and are not imagined. . . . Role-taking, as an adjustive process, enables the individual to control his behavior in accordance with the demands and expectations of other persons" (106, p. 68). It is thus the basis for social learning, the means by which the individual becomes aware of and is able to acquire the attitudes, values, and standards of behavior of his society and culture.

The loss of the role-taking ability means that the individual is unable to see himself as others see him. "The more a person can face, assess, and correct himself, the greater is his tendency toward ordered behavior and personal development. His behavior tends to become spontaneous, problem-centered, self-realizing, rather than self-inverted and distracted by helpless self-concern. On the other hand, the less one can accept himself, the more he has to hide behind illusional or delusional self-images and to obscure his 'real self.' He becomes less amenable to self-correction in terms of attainable aspirations and social demands and more fixed in his orientation to himself and others" (106, p. 80). Since role-taking

is the basis for communication (72), it is apparent that defects in communication develop with the loss of the role-taking ability.

As suggested in the preceding section, the self is a social product, developing in the process of social interaction which involves role-taking. Defects in this process might occur because of some innate or constitutional inadequacy of the individual which prevents him from being able to engage in role-taking experience, or may be the result of the social environment of the individual. Leighton writes that "For optimal development, the person must, especially in the formative years, interact with a fair cross section of people so that a suitable balance of sentiment patterns can be achieved. If the opportunity for developing a variety of those relationships is limited, or if the range of associates is weighted with persons who themselves suffer from psychiatric disorder, damaging consequences to the personality may occur" (66).

The basic significance of self-esteem in personality disorder is becoming increasingly recognized and will be discussed in a later chapter. Here it is pertinent to point out that an individual's conception of himself develops in a social situation, in interaction with others, so that the concepts others have of an individual affect his concept of himself. As Mullahy points out in his introduction to *A Study of Interpersonal Relations* (75, p. xxv), the child has no data for appraising himself except as he learns from others, and he tends to accept their judgments as to his worth. "Hence, the self comes to be made up of reflected appraisals. One learns to appraise his own worth as it has been appraised by others." Presumably all societies include threats to the individual's self-esteem. What constitutes a threat is defined by the society, so that what a person perceives as a threat to his sense of self-esteem is determined by the culture.

Sociologists and others have also studied the relation between occupation and mental and emotional disturbance (13, 14, 37, 65, 79, 80, 90). Mental hospital patients come more frequently from the lower occupational groups. A number of studies has also been

made of the social class origin of psychiatric patients. A study by Tietz, Lemkau, and Cooper (102) found that schizophrenic patients more frequently came from the dependent or marginal economic levels than did manic-depressives. Fuson's (38) paper supported the results for schizophrenics, though he found that manic-depressives were distributed fairly evenly throughout the various occupational levels. Clark (13, 14) reported similar results, with rates for schizophrenia correlating inversely with occupations ranked for income and prestige, while rates for manic-depressive psychoses showed no correlation with income and prestige. Frumkin (37) and Lantz (65) reported similar findings. Rose and Stub (91) summarize briefly a large number of studies in this area, all showing substantial agreement.

A series of papers by Hollingshead, a sociologist, and Redlich, a psychiatrist, report the results of a study of all patients receiving psychiatric treatment on a specified date in one community (46, 47, 48, 49, 50, 86, 87, 88). Psychoses were found to increase from the higher to the lower socio-economic classes. A reverse relationship was found in the case of psychoneurotics. These results may be questioned as to their significance, since they are not based on a search for emotionally disturbed individuals in the population, but on those who were actually in contact with treatment sources. There are probably social class differences in the recognition of emotional disturbance, in seeking help for the condition, and in the sources from which help is sought. Psychoneurosis, for example, may be more prevalent in the lower classes than the results indicate, but may go unrecognized, by both the individual and his associates, or may not be considered to be cause for seeking help. Kaplan, *et al.* (58) compared the incidence of psychoses in two communities of widely different socio-economic levels. While the incidence of hospitalized psychoses was much greater in the community with the lower socio-economic level, the incidence of non-hospitalized psychoses was higher in the high level community.

The combined rate was higher in the lower level community, however.

Statistics on the social class origin of personality disorders have led to the proposal of a "social drift" theory of psychoses, particularly schizophrenia (12; 13; 81, pp. 94-95). According to this theory, the inadequate individual drifts or filters down into the lower socio-economic levels before overtly becoming psychotic. Hollingshead and Redlich (48) found no evidence of downward mobility in their study. They actually found evidence of upward mobility among both schizophrenics and psychoneurotics in the proprietor and white-collar, and skilled worker classes (46, 48, 50). The whole question of the relationship of personality disorders to social class is at present unclear.

In this area of the relations of culture to personality disorder, as in the section on personality and culture, we have been able to do no more than touch upon some of the significant concepts and problems, and to direct the student to some of the sources of information.

The cultural environment of the individual is clearly involved in the emotional disturbances from which he suffers. The details of the influence are not entirely clear (95). But they seem to include a number of elements. The individual, as Aristotle pointed out, is a political or social being. As such, he needs to belong to a group, to be accepted, and to have a status and a role or roles in the group. Problems arise when the individual, whether because of his own inadequacies, or the nature of the society in which he lives, has difficulty in being accepted and in filling an accepted role. Membership in an underprivileged or rejected minority group may not be sufficient for emotional adjustment. A society in rapid transition or in process of disorganization may not offer sufficient opportunity for stable group membership or acceptance. The individual may thus become isolated. Or, if he is, by birth or training, greatly different from the group or unable to communicate ade-

quately with the group, he may become isolated. In either case, role-taking ability is affected, and thus communication is impaired.

The effects of social and cultural factors appear to operate through influencing the individual's concept of himself, and thus his self-esteem. The individual tends to accept the public or social definition of himself. This process and condition of self-derogation and loss of self-esteem is the essence of emotional disturbance, and will be elaborated in later chapters.

COUNSELING AND CULTURAL BACKGROUND

Mead (74) suggests that psychotherapy is one measure designed by society to help those individuals who are the victims of cultural strains. It represents the "efforts of a disoriented society to develop human beings who will be strong enough to survive and participate constructively in creating new cultural forms which will again restore some order to human life." Seward (96, p. 23) sees psychotherapy as one of the sources through which the individual in a complex society with many sources of conflict can achieve integration and utilize the social diversities for creative growth, thus avoiding disintegration.

Since culture, or the society in which the individual grows up, has such strong influences upon personality and the nature of its disturbances and disorders, it would appear that counselors and psychotherapists should be familiar with the cultural backgrounds of their clients. Relatively little attention has been given to this area in counseling. Perhaps the assumption that counselors and clients are from the same society or culture has been responsible for this lack of attention. The recent studies of subcultures or of classes within a larger culture, such as American society, have made us aware that there are wide differences in cultural and social backgrounds among those who come to counselors or psychotherapists for help.

The preceding chapter discussed the influence of cultural factors on the therapist's values, and the goals of the therapeutic process.

Davis (22) presents a critical review of the mental hygiene movement as a manifestation of the contemporary mobile class system and its philosophy. This chapter will consider the influence of the cultural background of the client on the therapeutic process, and its significance for the counselor or therapist.

To continue formulation of the social nature of personality and its disorders, it is assumed that if such disorders arise from misconceptions of the self resulting in lowered self-esteem, which in turn involves faulty interpersonal relations or defects in the role-taking ability and process, then therapy is necessarily a social situation whose purpose or function is to reverse the process which has led to the personality disorder. This social situation is affected by the attitudes of the client and the therapist toward each other, and toward the therapeutic process.

ATTITUDES TOWARD PSYCHOTHERAPY

Attitudes toward psychotherapy and the psychiatrist or therapist are related to the attitude toward specialists and authority in our society. The doctor, the lawyer, the engineer, and the teacher are looked upon as people who do things to and for their clients. The relationship which develops with them is one of dependency, of reliance upon authority. The psychotherapist, be he a physician or not, is identified as an authority. The attitudes and expectations of the client are influenced by this fact. "Because of childhood experiences with physicians, the physician-patient relationship is the signal to the patient for the assumption of passive-feminine-masochistic patterns" (71). Ruesch writes that "The permissive psychiatrist and his actions are on the whole a surprising experience for the patient. The latter is used to the fact that people in his surroundings are intent on reinforcing the prevailing cultural trends" (92, pp. 127-128).

While in the past the therapist-client relationship tended to conform more to this authoritarian or dependency pattern, there has been a change to a situation where the client is expected, even

required, to assume the major responsibility for the therapeutic relationship. Cultural changes have affected psychotherapy, with a shift from authoritarianism to self-direction. The dependency relationship of physician-patient is felt to be inimical to a profitable or successful therapeutic relationship. Rogers (89) has clearly pointed out the differences in the two types of relationship. There is evidence that increasingly in even the traditional doctor-patient relationship, "The state of dependence on professional assistance . . . is relatively institutionalized in our society as undesirable" (103).

However, there are variations in this rejection of dependency among the social classes. While, partly perhaps as a result of publicity regarding the role of the client in psychotherapy, the upper classes are prepared for the permissiveness of the therapist, there is evidence that the lower social classes still look upon the physician and the therapist as authority figures. Redlich, Hollingshead, and Bellis (86) studied the attitudes of patients in two social classes (Class III, white collar and skilled workers; and Class V, unskilled workers) toward psychiatry. Patients in both classes found it difficult to accept responsibility for exploring their own emotions. Among those who were willing to talk about their problems, some expected that after they had done so the doctor would "treat" them. Most of the patients (neurotics) were passive, and expected "pills and needles" and were disappointed at not receiving such treatment. Stotsky (100) found that lower class hospital patients preferred manual, occupational, and recreational activities to "talking with the doctor about problems," and regarded psychotherapy as relatively less important in helping to bring about their recovery from mental illness.

Clients from the lower classes associate therapy with medical treatment of physical conditions. Middle and upper class clients have been exposed to descriptions of the procedures of psychotherapy, and therefore know better what to expect and what is expected of them. Psychotherapy is a verbal or "talking" treat-

ment. The ability to talk about oneself varies with social level, apparently. The lower classes are less verbal, generally, possibly in part because they have less need for verbalization in their occupations. They therefore do not find it easy to talk about themselves, to make themselves understood, in psychotherapy.

These attitudes and expectations plus the deficiency in verbalization create difficulties in psychotherapy. Beaglehole (5) points out that when the therapist and client are from different cultures there are problems of communication. This applies as well to differences in social class.

SOCIAL CLASS AND TREATMENT

The varying difficulty in applying a therapy based on verbalization and communication affects the treatment given individuals from different social classes. Robinson, Redlich, and Myers (88) studied 1963 patients in mental hospitals or receiving psychiatric treatment in a community in 1950. They found that the type of treatment received varied with social class. Seventy-nine percent of those in Classes I and II were receiving psychotherapy, compared to 16 percent of those in Class V. Conversely, 33 percent of those in Class V were receiving organic treatment (drugs, shock, or surgery) compared to 12 percent of those in Classes I and II. Only 9 percent of those in the two upper classes were receiving custodial treatment, compared to over 51 percent of those in Class V. Members of the upper classes diagnosed as schizophrenics are treated by private psychiatrists or in private hospitals; those in the middle classes start treatment on a private basis, but after a year or so move to a State hospital. The lower class patients go directly to the State hospital (48). In the case of schizophrenia, 75 percent of those in Class V received organic treatment, compared to 17 percent of those in Classes I and II; while 83 percent of those in Classes I and II received psychotherapy, compared to 9 percent of Class V who received individual psychotherapy, although another 9 percent received group psychotherapy (48). The differential

distribution of the psychoses and psychoneuroses among the social classes, referred to above, may account for some of the difference. However, the differences were still significant when analyzed separately for differing diagnoses.

Where psychotherapy is provided, it has been found that the type and intensity or duration vary among the social classes. Robinson, Redlich and Myers (88) analyzed the type of treatment given to patients in the study referred to above, distinguishing five types: psychoanalysis, analytic therapy, eclectic therapy, relationship therapy (supportive, directive, and suggestive), and group therapy. Classes I and II preponderantly were treated by psychoanalysis; Class III received analytic, eclectic, and relationship therapy; Class IV, eclectic and group but mainly relationship therapy; and Class V these same three but mainly group therapy.

Myers and Schaffer (78) studied 195 clinic cases, 47 diagnosed as psychotic and 148 as neurotic. Of applicants to the clinic, nearly two-thirds of those from Class V, one-fifth of those from Class IV, and one-tenth of those from Classes II and III (there were no Class I cases) were *not* recommended for therapy.

Duration of psychotherapy is also related to social class. In one study (2) the mean number of interviews for upper and lower middle class patients was 24.7, while for the two lowest classes it was 11.0. Myers and Schaffer report a similar finding (78). Another study (55) held constant the experience and training of the therapists and eliminated the selection of clients by the therapists; moreover, both therapists and clients were encouraged to continue treatment for at least six months. Clients were divided into lower and middle classes. At the time of the study, the lower class clients had had an average of 11.6 interviews, and the middle class clients had had an average of 16.4; one-eighth of the lower class clients and one-third of those in the middle class were still in treatment. Another study, of Veterans Administration Mental Hygiene Clinic patients (107), found the same relationship between social class and duration of treatment. This study also found

that there was a tendency to utilize a more intensive, analytic type of therapy with clients in the upper classes, while those in the lower classes more often were given a supportive type of therapy.

There is evidence that clients in a clinic are selectively assigned to therapists by social class. In the study of Myers and Schaffer (78), staff psychiatrists treated Class II and III clients mainly, while residents in training treated mainly Class IV and V clients. This circumstance is probably related to duration of treatment; in most of the studies cited above, however, this factor was controlled.

CLIENT EXPECTATIONS AND TREATMENT METHODS

It is apparent that the different social classes come to psychotherapy with differing attitudes and expectations, and a varying readiness to adapt to its requirements and procedures. It appears likely that different age groups also have differing expectations. Several studies (34, 41, 98) suggest that high school, and even college, students prefer counselors who are not client-centered in approach, but who are more active and directive. These studies are subject to some serious criticisms, however (82). They fail to distinguish between educational-vocational and therapeutic counseling, which may involve differing techniques or degrees of activity in the counselor. And they tend to confuse passivity with client-centeredness. Nevertheless, there seems to be some evidence that students, presumably influenced by the general attitudes toward professional specialists, and the identification of the counselor with the teacher, assume and express a preference for the passive, submissive role of the student in the counseling situation (83). There has been some suggestion (98) that perhaps counselors should comply with the student's preference in their counseling approach. Before this is done, however, it is suggested that careful consideration be given to the basic desirability of such a step. It would appear to be inconsistent with the developing trend toward independence and responsibility of the individual in our

society, and with the goals of therapy as outlined in the previous chapter. There is considerable question regarding the empirical value of such a step. The experience of therapists seems to agree with that of Redlich *et al.* (86), that modification of technique in the direction of the therapist taking responsibility is not effective in achieving progress in therapy. They report that when therapists changed from insight therapy to a supportive treatment, clients still "tended to be disappointed at not getting sufficient practical advice about how to solve their problems and how to run their lives." Perhaps complying with the client's desire to be dependent only strengthens his dependency demands. There is also some evidence in addition to that from experience, that clients are able to learn to take responsibility in the counseling relationship (19).

CULTURAL BACKGROUND AND TREATMENT METHODS

The importance of cultural factors in the practice of psychotherapy has not been clearly delineated. The client's position in society, his social class, occupation, income and community status do of course influence the attitudes of the therapist toward him. The attitudes of the therapist and the client toward each other are related, are affected by the cultural background of each, and influence the therapeutic process. Therapists are usually from the middle or upper classes; whether the client is from a higher or lower class may affect the relationship which develops. Some, e.g., De Grazia (23), feel that the authority of the therapist, one aspect of which may be social class, is essential for successful therapy.

There is perhaps an implication that clients with different cultural backgrounds should be handled differently in therapy. Seward (96, p. 10) suggests this in her statement that culturally determined "variability in personality dynamics . . . calls for variability in therapeutic handling." She fails to specify this in her book, however. Earlier she states that she has not included a discussion of the client-centered approach in her book because it is "narrowly focused on interpersonal relations. The broader cultural

implications are not sufficiently spelled out to establish this movement as a specifically cultural approach to psychotherapy" (96, p. vi). In one sense the client-centered point of view is strongly culturally oriented, being an example, only slightly more extreme than most current psychotherapies, of the contemporary American or Western attitude toward the individual (See Chapters 4 and 6). Its basic philosophy and attitudes are thus strongly fixed, and its approach is universally applied to all clients without modification, though specific techniques do of course vary.

But it does not appear to be necessary to change the therapeutic approach to clients of differing backgrounds. The essential significance of cultural differences among clients, and between the client and the therapist, is the effect on communication and the understanding of the client by the therapist. The basic approach remains the same. As the psychoanalyst handles all elements entering the therapeutic situation in the same way, i.e., by interpretation, so the client-centered therapist attempts to handle them all in the same way, i.e., by understanding them. Since understanding is prerequisite to interpretation, the significance of cultural differences is the same for psychoanalysts and client-centered therapists, as well as for other interpretive therapists. All need to understand the client. Communication is essential for understanding, and communication is hampered by differences in social and cultural background, language, or even sex.

The therapist must therefore be familiar with the meaning of cultural and social factors in the client's life in order to understand him as an individual. Even the therapist who works almost entirely with clients from his own culture or social class will benefit from some familiarity with other cultures and classes, first, in order to be alert to his atypical clients, and secondly to add to his understanding of human nature and its variability in general. Slotkin's statement about psychiatry in general applies to psychotherapy: "The major contribution of anthropology to symptomatology [read 'psychotherapy'] is the opportunity it offers for reducing the

ethnocentrism of the diagnostician [read 'psychotherapist']" (97). Opler (81, p. 209) also makes essentially the same point. The therapist should have, therefore, some familiarity with cultural anthropology, though perhaps it is too much to expect, as Abel (1) suggests, that he have formal training in this field.

Devereaux (25), discussing the place of cultural factors in psychoanalytic therapy, distinguishes two types of situations. In the first, which he calls "transcultural psychotherapy," the therapist must understand the general nature and function of culture *per se*, but need not be closely familiar with any particular culture, including the culture of the client. In the other, termed "cross-cultural therapy," the therapist has a detailed acquaintance with the particular culture of the client prior to therapy. He suggests that the first approach may require a cultural neutrality (25, p. 222). Devereaux goes on to point out some of the problems when client and therapist are from different cultures. One danger is the exploitation of the difference by the client, by going into a detailed discussion of his culture as a defense. Another danger is the client's attempting to "teach" the therapist his culture, a situation which may develop between an American client and a foreign born therapist. Again, the therapist may become interested in the details of the client's culture for itself, and see the client as a type, or a source of information, rather than as a client and a person. Yet the therapist must be interested in the culture of the client and seek to understand his productions in terms of his own culture. Devereaux suggests that the therapist should learn about the client's culture before beginning therapy, to avoid these problems. No specific changes in technique appear to be indicated by Devereaux, however. He does suggest that the basic rule of interpretation (i.e., interpret whatever is nearest to the threshold of the conscious) may be modified in some cases. That is, things which may not be interpreted until late in therapy in one case may be interpreted earlier in a case from a different culture if the material is something which in the first culture may be deeply repressed, but only

minimally repressed in the other. This, however, is not actually a change in technique, but only the use of standard technique on the basis of better understanding.

The importance of a broad and intensive knowledge of social and cultural factors in personality and its disorders, then, seems to rest on the basis of its contribution to an understanding of the client by the therapist. Communication is facilitated. The problem of the inadequacy of communication because of difficulty in verbalization, whether this is the result of culture, social class, low intelligence or psychosis, has not been resolved. Psychotherapy is dependent upon communication, and while to some extent communication may be nonverbal, it is doubtful if psychotherapy could be successful without verbalization. Redlich *et al.* (86) suggest that "while at this time, insight therapy is less likely, in our opinion, to be grasped by the lower classes than physical therapy or a therapy employing 'magical' methods, as we gain knowledge in psychiatric techniques the patient's empathy will become less and less necessary." They do not suggest the possible nature of these techniques. They do indicate that while insight or expressive therapy is not effective with clients from the lower classes, this is not a basis for using supportive or suggestive techniques, but is rather "a challenge to find appropriate methods for all kinds of patients."

For those clients in the lower classes whose basic conflicts are with their environment, environmental manipulation is often suggested. Group therapy and activity groups, as well as the use of natural groups, have also been suggested, and have been used with underprivileged delinquents. But for those whose conflicts are internal, and who need more than, or something other than, manipulation of the environment or group membership, the ability to verbalize appears essential for psychotherapy. The organic treatment methods (shock and drugs) are useful in some cases because they make the client accessible to psychotherapy. Children communicate in play and the use of toys and other materials.

Adults can also utilize various art media to express themselves to some extent—nonverbal contacts have been successful in some cases of severe psychotics. But none of these methods has completely met the need or provided the approach to all types of nonverbal clients. And in all approaches, the need for understanding of the client by the therapist is present, and is, indeed, an essential factor in the therapy.

REFERENCES

1. Abel, Theodora M. Cultural patterns as they affect psychotherapeutic procedures. *Amer. J. Psychother.*, 1956, 10:728-739.
2. Auld, F., & Myers, J. K. Contributions to a theory for selecting psychotherapy patients. *J. clin. Psychol.*, 1954, 10:56-60.
3. Azima, H., & Cramer, Fern J. Effects of partial perceptual isolation in mentally disturbed individuals. *Dis. nerv. System*, 1956, 17:117-122.
4. Barnett, H. G. Personal conflicts and cultural change. *Social Forces*, 1941, 20:160-171.
5. Beaglehole, E. Cultural complexity and psychological problems. In P. Mullahy (Ed.), *A study of interpersonal relations*. New York: Hermitage, 1949.
6. Benedict, P. K., & Jacks, I. Mental illness in primitive societies. *Psychiatry*, 1954, 17:377-389.
7. Benedict, Ruth. *Patterns of culture*. Boston: Houghton Mifflin, 1934.
8. Benedict, Ruth. Continuities and discontinuities in cultural conditioning. In C. Kluckhohn & H. A. Murray (Eds.), *Personality in nature, society, and culture*. (2nd ed.) New York: Knopf, 1953.
9. Benedict, Ruth. Anthropology and the abnormal. In D. G. Haring (Comp.), *Personal character and cultural milieu*. (3rd rev. ed.) Syracuse: Syracuse University Press, 1956.
10. Bidney, D. Towards a psychocultural definition of the concept of personality. In S. S. Sargent & Marian W. Smith (Eds.), *Culture and personality*. New York: Viking Fund, 1949.
11. Burgess, E. W. The cultural approach to the study of personality. *Ment. Hyg.*, 1930, 14:307-325.
12. Burgess, E. W. Social factors in the etiology and prevention of mental disorders. *Social Prob.*, 1953, 1:53-56.
13. Clark, R. E. The relationship of schizophrenia to occupational income and occupational prestige. *Amer. sociol. Rev.*, 1948, 13:325-330.
14. Clark, R. E. Psychoses, income, and occupational prestige. *Amer. J. Sociol.*, 1949, 44:433-440.

15. Clausen, J. A. *Sociology and the field of mental health*. New York: Russell Sage Foundation, 1956.
16. Clausen, J. A., & Kohn, M. L. The ecological approach to social psychiatry. *Amer. J. Sociol.*, 1954, 60:140-149.
17. Cooley, C. H. *Human nature and the social order*. New York: Scribner, 1902.
18. Cooper, J. M. Mental disease situations in certain cultures—a new field for research. *J. abnorm. soc. Psychol.*, 1934, 29:9-17.
19. Danskin, D. G. Roles played by counselors in their interviews. *J. counsel. Psychol.*, 1955, 2:22-27.
20. Davis, A. American status systems and the socialization of the child. In C. Kluckhohn & H. A. Murray (Eds.), *Personality in nature, society, and culture*. (2nd ed.) New York: Knopf, 1953.
21. Davis, A., & Havighurst, R. J. Social class and color differences in child rearing. In C. Kluckhohn & H. A. Murray (Eds.), *Personality in nature, society, and culture*. (2nd ed.) New York: Knopf, 1953.
22. Davis, K. Mental hygiene and the class structure. In P. Mullahy (Ed.), *A study of interpersonal relations*. New York: Hermitage, 1949.
23. De Grazia, S. *Errors in psychotherapy*. Garden City, New York: Doubleday, 1952.
24. Devereaux, G. A sociological theory of schizophrenia. *Psychoanalytic Rev.*, 1934, 26:315-342.
25. Devereaux, G. Cultural factors in psychoanalytic therapy. In D. G. Haring (Comp.), *Personal character and cultural milieu*. (3rd rev. ed.) Syracuse: Syracuse University Press, 1956.
26. Dunham, H. W. The social personality of the catatonic-schizophrenic. *Amer. J. Sociol.*, 1944, 49:508-518.
27. Dunham, H. W. Some persistent problems in the epidemiology of mental disorder. *Amer. J. Psychiat.*, 1953, 109:567-575.
28. Dunham, H. W. The current status of ecological research in mental disorder. In A. Rose (Ed.), *Mental health and mental disorder: a sociological approach*. New York: Norton, 1955.
29. Eaton, J. W., & Weill, R. J. *Culture and mental disorder*. Glencoe, Ill.: Free Press, 1954.
30. Faris, E. *The nature of human nature*. New York: McGraw-Hill, 1937.
31. Faris, R. E. L. Cultural isolation and the schizophrenic personality. *Amer. J. Sociol.*, 1934, 40:155-169.
32. Faris, R. E. L. Reflections of social disorganization in the behavior of a schizophrenic patient. *Amer. J. Sociol.*, 1944, 50:134-141.
33. Faris, R. E. L., & Dunham, H. W. *Mental disorders in urban areas*. Chicago: University of Chicago Press, 1939.

34. Forgy, E. W., & Black, J. D. A follow-up after three years of clients counseled by two methods. *J. counsel. Psychol.*, 1954, 1:1-8.
35. Fromm, E. Individual and social origins of neurosis. In C. Kluckhohn & H. A. Murray (Eds.), *Personality in nature, society, and culture*. (2nd ed.) New York: Knopf, 1953.
36. Frumkin, R. M. Education and mental illness: a preliminary report. *Educ. Res. Bull., Ohio State Univer.*, 1953, 32:212-214.
37. Frumkin, R. M. Occupation and major mental disorder. In A. Rose (Ed.), *Mental health and mental disorder: a sociological approach*. New York: Norton, 1955.
38. Fuson, W. M. Research note: occupations of functional psychotics. *Amer. J. Sociol.*, 1943, 48:612-613.
39. Galdston, I. (Ed.) *Freud and contemporary culture*. New York: International Universities Press, 1957.
40. Goldhamer, H., & Marshall, A. W. *Psychosis and civilization*. Glencoe, Ill.: Free Press, 1953.
41. Grigg, A. E., & Goodstein, L. D. The use of clients as judges of the counselor's performance. *J. counsel. Psychol.*, 1957, 4:31-36.
42. Hallowell, A. I. Culture and mental disorder. *J. abnorm. soc. Psychol.*, 1934, 29:1-9.
43. Hallowell, A. I. Acculturation processes and personality changes. In C. Kluckhohn & H. A. Murray (Eds.), *Personality in nature, society, and culture*. (2nd ed.) New York: Knopf, 1953.
44. Hallowell, A. I. *Culture and experience*. Philadelphia: University of Pennsylvania Press, 1955.
45. Hebb, D. O. The mammal and his environment. *Amer. J. Psychiat.*, 1955, 111:826-831.
46. Hollingshead, A. B., Ellis, R., & Kirby, E. Social mobility and mental illness. *Amer. sociol. Rev.*, 1954, 19:577-584.
47. Hollingshead, A. B., & Redlich, F. C. Social stratification and psychiatric disorders. *Amer. sociol. Rev.*, 1953, 18:163-169.
48. Hollingshead, A. B., & Redlich, F. C. Social stratification and schizophrenia. *Amer. sociol. Rev.*, 1954, 19:302-306.
49. Hollingshead, A. B., & Redlich, F. C. Schizophrenia and social structure. *Amer. J. Psychiat.*, 1954, 110:695-701.
50. Hollingshead, A. B., & Redlich, F. C. Social mobility and mental illness. *Amer. J. Psychiat.*, 1955, 112:179-185.
51. Honigmann, J. J. *Culture and personality*. New York: Harper, 1954.
52. Horney, K. *The neurotic personality in our time*. New York: Norton, 1937.
53. Horney, K. *Our inner conflicts*. New York: Norton, 1945.
54. Hunt, J. McV. An instance of the social origin of conflict resulting

- in psychoses. In C. Kluckhohn & H. A. Murray (Eds.), *Personality in nature, society, and culture*. (2nd ed.) New York: Knopf, 1953.
55. Imber, S. D., Nash, E. H., Jr., & Stone, A. R. Social class and duration of psychotherapy. *J. clin. Psychol.*, 1955, 11:281-284.
 56. Inkeles, A. Some sociological observations on culture and personality studies. In C. Kluckhohn & H. A. Murray (Eds.), *Personality in nature, society, and culture*. (2nd ed.) New York: Knopf, 1953.
 57. Jaco, E. G. The social isolation hypothesis and schizophrenia. *Amer. sociol. Rev.*, 1954, 19:567-577.
 58. Kaplan, B., Reed, R. B., & Richardson, W. A comparison of the incidence of hospitalized and non-hospitalized cases of psychosis in two communities. *Amer. sociol. Rev.*, 1956, 21:472-479.
 59. Kardiner, A. *The individual and his society*. New York: Columbia University Press, 1939.
 60. Kardiner, A. *The psychological frontiers of society*. New York: Columbia University Press, 1945.
 61. Klineberg, O. Recent studies of national character. In S. S. Sargent & Marian W. Smith (Eds.), *Culture and personality*. New York: Viking Fund, 1949.
 62. Kluckhohn, C., & Mowrer, O. H. Culture and personality: a conceptual scheme. *Amer. Anthropologist*, 1944, 46:1-29.
 63. Kohn, M. L., & Clausen, J. A. Social isolation and schizophrenia. *Amer. sociol. Rev.*, 1955, 20:265-273.
 64. Kroeber, A. L. *Anthropology*. (New ed., rev.) New York: Harcourt Brace, 1948. Ch. 15.
 65. Lantz, H. R. Occupational differences in mental disorders. *Social Prob.*, 1954, 2:100-104.
 66. Leighton, A. H. Psychiatric disorder and social environment: an outline for a frame of reference. *Psychiatry*, 1955, 18:367-383.
 67. Lindesmith, A. R., & Strauss, A. L. A critique of culture-personality writings. *Amer. sociol. Rev.*, 1950, 15:587-600.
 68. Linton, R. *The study of man*. New York: Appleton-Century, 1936.
 69. Linton, R. *The cultural background of personality*. New York: Appleton-Century, 1945.
 70. Linton, R. *Culture and mental disorders*. Springfield, Ill.: Thomas, 1956.
 71. Mann, L. Child-physician, patient-therapist: role and transference problems. *Psychoanalysis*, 1955, 4:67-70.
 72. Mead, G. H. *Mind, self and society*. Chicago: University of Chicago Press, 1934.
 73. Mead, Margaret. The concept of culture and the psychosomatic approach. In D. G. Haring (Comp.), *Personal character and cultural milieu*. (3rd rev. ed.) Syracuse: Syracuse University Press, 1956.

74. Mead, Margaret. The implications of culture change for personality development. In D. G. Haring (Comp.), *Personal character and cultural milieu*. (3rd rev. ed.) Syracuse: Syracuse University Press, 1956.
75. Mullahy, P. (Ed.) *A study of interpersonal relations*. New York: Hermitage, 1949.
76. Murphy, G. The relationships of culture and personality. In S. S. Sargent & Marian W. Smith (Eds.), *Culture and personality*. New York: Viking Fund, 1949.
77. Myers, J. K., & Roberts, B. H. A sociological psychiatric case study of schizophrenia. *Sociol. soc. Res.*, 1954, 39:11-17.
78. Myers, J. K., & Schaffer, L. Social stratification and psychiatric practice: a study of an out-patient clinic. *Amer. sociol. Rev.*, 1954, 19:307-310.
79. Nolan, W. J. Occupation and manic-depressive psychoses. *State Hosp. Quart.*, 1918, 4:75-102.
80. Nolan, W. J. Occupation and dementia praecox. *State Hosp. Quart.*, 1918, 3:127-154.
81. Opler, M. K. *Culture, psychiatry and human values: the methods and values of social psychiatry*. Springfield, Ill.: Thomas, 1956.
82. Patterson, C. H. Comment on T. R. Sonne & L. Goldman. "Preferences of authoritarian and equalitarian personalities for client-centered and eclectic counseling." *J. counsel. Psychol.*, 1957, 4:250-251.
83. Patterson, C. H. Client expectations and social conditioning. *Personnel Guid. J.*, 1958, 37:136-138.
84. Plant, J. *Personality and the cultural pattern*. New York: Commonwealth Fund, 1937.
85. Redlich, F. C. Some sociological aspects of the psychoses. In *Theory and treatment of the psychoses: some newer aspects*. Papers presented at the dedication of the Renard Hospital, St. Louis, October, 1955. St. Louis: Washington University Press, 1956.
86. Redlich, F. C., Hollingshead, A. B., & Bellis, Elizabeth. Social class differences in attitudes towards psychiatry. *Amer. J. Orthopsychiat.*, 1954, 25:60-70.
87. Redlich, F. C., et al. Social structure and psychiatric disorders. *Amer. J. Psychiat.*, 1953, 109:729-734.
88. Robinson, H. A. Redlich, F. C., & Myers, J. K. Social structure and psychiatric treatment. *Amer. J. Orthopsychiat.*, 1954, 24:307-316.
89. Rogers, C. R. A physician-patient or a therapist-client relationship? In M. H. Krout (Ed.), *Psychology, psychiatry and the public interest*. Minneapolis: University of Minnesota Press, 1956.
90. Rose, A. (Ed.) *Mental health and mental disorder: a sociological approach*. New York: Norton, 1955.

91. Rose, A., & Stub, H. Summary of studies on the incidence of mental disorders. In A. Rose (Ed.), *Mental health and mental disorder: a sociological approach*. New York: Norton, 1955.
92. Ruesch, J., & Bateson, G. *Communication: the social matrix of psychiatry*. New York: Norton, 1951.
93. Schaffer, L., & Myers, J. K. Psychotherapy and social stratification: an empirical study of practice in a psychiatric out-patient clinic. *Psychiatry*, 1954, 17:83-93.
94. Schilder, P. The sociological implications of neurosis. *J. soc. Psychol.*, 1942, 15:3-21.
95. Scott, W. A. Some psychological correlates of mental illness and mental health. *Psychol. Bull.*, 1958, 55:65-87.
96. Seward, Georgene H. *Psychotherapy and cultural conflict*. New York: Ronald, 1956.
97. Slotkin, J. S. Culture and psychopathology. *J. abnorm. soc. Psychol.*, 1955, 51:269-275.
98. Sonne, T. R., & Goldman, L. Preferences of authoritarian and equalitarian personalities for client-centered and eclectic counseling. *J. counsel. Psychol.*, 1957, 4:129-135.
99. Spiro, M. E. Culture and personality: the natural history of a false dichotomy. *Psychiatry*, 1951, 14:18-46.
100. Stotsky, B. A. How important is psychotherapy to the hospitalized psychiatric patient? *J. clin. Psychol.*, 1956, 12:32-36.
101. Sullivan, H. S. *The interpersonal theory of psychiatry*. (Ed. by Helen Swick Perry & Mary Ladd Gawel.) New York: Norton, 1953.
102. Tietz, C., Lemkau, P., & Cooper, Marcia. Schizophrenia, manic depressive psychoses and social economic status. *Amer. J. Sociol.*, 1941, 47:167-175.
103. Treudley, Mary B. The analysis of the dependency role in American culture. *Social Casework*, 1952, 33:203-208.
104. Warner, W. L. The society, the individual, and his mental disorders. *Amer. J. Psychiat.*, 1937, 94:275-284.
105. Weinberg, S. K. A sociological analysis of a schizophrenic type. *Amer. sociol. Rev.*, 1950, 15:600-610.
106. Weinberg, S. K. *Society and personality disorders*. New York: Prentice-Hall, 1952.
107. Winder, A., & Hersko, M. The effect of social class on the length and type of psychotherapy in a Veterans Administration Mental Hygiene Clinic. *J. clin. Psychol.*, 1955, 11:77-79.

PART III

THE THERAPEUTIC RELATIONSHIP

CHAPTER 6

Two Approaches to Human Relations

Within the last generation there has been evidence of a change in various fields of human relations from a relatively authoritarian approach to a more egalitarian one. This change has reflected a general cultural change in attitudes toward the individual. Family relationships have become more democratic, as has education, and to some extent industry also.

Nevertheless, this change has not been complete in any area, even in the field of psychotherapy. Methods of dealing with people, of human relations, appear to be divisible into two major types which are in conflict with each other. This division and conflict seem to exist in each field of human relations. Gordon (14, ch. 2) analyzes the two approaches in terms of two conflicting views of the nature of man. One reflects a positive, optimistic, encouraging view, while the other is based on a negative, pessimistic, discouraging view.

UNDERSTANDING

The first point of view is associated with respect for the individual and his self-autonomy. His right to freedom of choice, for self-determination of his behavior, for living his own life is recognized. On the other hand, the second point of view sees the indi-

vidual as one who cannot take responsibility for himself, who cannot be trusted to make his own decisions. Rather he needs to be controlled from the outside. He cannot be given freedom to make his own decisions to live his life as he sees fit.

To be sure, these are descriptions of extremes, and there is a broad area in between. Nevertheless, the extremes must be recognized; they do exist in some instances, and they are the end results of two opposed attitudes toward human beings. Politically, the two approaches are represented by the democratic and authoritarian or totalitarian philosophies of government. But the conflict extends throughout all areas of human relations.

The first approach to human relations appears to be based on an understanding of the individual as a distinct, unique, self-autonomous human person or self. There is an attempt to understand the feelings, needs, desires, motives, attitudes, etc., of the individual, and to respect them rather than to attempt to influence or to control them. We shall therefore designate this as the *understanding approach* to human relations.

MANIPULATION

The second approach to human behavior appears to be characterized by attempts to influence or control it. This control may be direct or indirect. There is relatively little respect for the individual, although there may be claims that the influence or control is for the presumed good of the individual being influenced or controlled. Whether this claim is sincere or not is immaterial; it is the fact of external control or influence which is the essence of this approach. There may be attempts to understand the individual's feelings, needs, and attitudes; but this is done for the purpose of influencing or changing them. Because of this aspect of manipulation, we shall designate this as the *manipulative approach* to human relations.

This latter point of view, while it may in some respects be designated as authoritarian, is not therefore to be considered as

necessarily inimical to the American tradition and philosophy. In fact, it is actually an expression of the American philosophy of efficiency. It represents an expression of the desire to get results in the shortest time, in the easiest and most direct way. In psychotherapy it represents a dissatisfaction with the length and complex involvements of orthodox psychoanalysis. It is perhaps an expression of American optimism about being able to achieve results ever more quickly and efficiently (1). Weinberg (51, p. 325) suggests that brief psychotherapy, in the manner of Alexander and French (2), with its manipulation of the process and the client by the therapist, is a manifestation of the influence of American society upon the social and psychological sciences. Ruesch writes: "Things have to be done fast in America, and therefore therapy has to be brief" (40, p. 148).

In addition to the American desire for efficiency and speed of results, there is another factor which supports the manipulative approach to human behavior. This is the influence of the scientific point of view. The objectives of science are commonly listed as understanding, prediction, and control. The physical sciences have set an example of the extent to which control of the physical environment is possible. The social sciences, in emulation, appear to be seeking to control human behavior to the same extent. When we go from understanding and prediction to control, we face certain problems. This is true in the physical sciences, where the uses to which such discoveries as atomic energy is put, raise questions which involve values and ethics. These questions include those of control by whom, for whom, and for what purposes. In the social and psychological fields there is the additional question of who controls whom. By what right does one individual control others? We shall consider this problem later.

IN GOVERNMENT

In the field of government, the implications of the need of the individual to have a sense of personal value are being recognized.

Mayo (25, ch. 7) called attention to this need in connection with his work in industry, suggesting that the sense of personal futility is not limited to the work situation. That the understanding of and respect for the individual is basic to democratic government would not be questioned. There is impressive evidence of the concern of government for the individual and his rights, from the development and expansion of social security programs, not as relief but as human rights provided as social insurance, to the recent recognition of the Fourteenth Amendment by the Supreme Court in the field of educational integration.

Nevertheless, it is also true that government, even democratic government, in its administration tends to become bureaucratic, and to disregard the individual as a person. Gellhorn points out areas in which such a tendency seems to have been developing in recent years. He says that, "to a degree not remotely approached in the past, American citizens are the objects of suspicion of administrators rather than the object of their services" (11, p. 38).

Leighton, in a study of the administration of a Japanese relocation camp during World War II, states some principles and recommendations for the governing of men. He concludes that "the problem which faces the administration of a community under stress is the problem of introducing remedial change . . . this does not mean that great change is always necessary, but only that great understanding is . . . not infrequently the natural reactions of self-healing in the community are adequate" (18, pp. 355-356).

In government, therefore, we see both of these trends. There are those who desire to manipulate the governed, either for their own purposes, or because of lack of trust in the governed to be responsible for themselves. "Society needs," says Gordon, "to evolve a kind of leadership that puts human values first, a leadership that facilitates man's realization of his creative capacities, man's free expression of his individuality, man's actualization of

his own uniqueness" (14, p. 3), free from the oppressive control of external authority.

IN INDUSTRY

In industry, perhaps the beginning of the recognition of the importance of understanding was in the Hawthorne experiment at Western Electric (25, 32), conducted between 1927 and 1932. In this study, five operators, engaged in relay assembly, were set off by themselves, and subjected to varying external conditions of work, including the introduction and then the elimination of rest pauses and midmorning food, changes in working hours, etc. It was found that regardless of changing conditions, including reversion to less favorable conditions, production increased continuously over the entire period. The girls expressed an increased satisfaction in work, and there was a decrease in absences. They attributed their better production to a greater freedom in the work situation, with opportunity to vary the pace at will, and to less strict supervision. However, supervision and company policy had been good prior to the experiment and no simple "error" of supervision could be uncovered. Interviews with about 20,000 other workers did not reveal any reliable or flagrant instances of poor supervision. There did emerge, however, some evidence of an experience of personal futility, related to feelings of constraint and interference in their work. While a background of out-of-work personal problems seemed to be involved in this feeling, there also appeared to be a lack of understanding of the work situation, involving poor communication between the working group, the supervisor, and company policies, resulting in conflicts of loyalties.

There was clearly a need for improved understanding of the workers' situation. This understanding was the effective factor in the experimental situation, and in the conduct of the interviews with other employees. Both the experimental situation and the interviews indicated interest in the individual, respect for the worker as an individual and for his opinions. A report made during the

study is quoted by Mayo as follows: "Much can be gained industrially by carrying greater personal consideration to the lowest levels of employment" (25, p. 69).

The increase in wages—real as well as absolute; shorter working hours; holidays; vacations with pay; and fringe benefits, which now can be numbered by the dozen, have not satisfied the worker in an industrial society. Studies of what the worker desires in a job indicate that these material rewards are not at the top of the list. There are variations in different studies and, where the economic returns are low, the material aspects rank high. Surveys indicate, however, that workers are interested in intangible or psychological satisfactions in their work—security, freedom, responsibility, independence and responsibility in doing one's work, good supervisory relationships, knowledge of one's status, interesting work, recognition and approval for achievements, fair treatment, and opportunity for self-expression (49, ch. 9). These represent a need and a desire to be recognized and treated as human individuals, a need to be accepted, understood, and informed. Morale in industry is largely a matter of such factors, rather than of wages and hours.

These human elements in the work situation are being recognized in industrial and personnel psychology, and by employers. A recent book in this field is concerned with "overcoming communication barriers, preventing misunderstandings, and developing the constructive side of man's nature" (23, p. vii). Industry's interest in employee morale and satisfaction is not, of course, entirely altruistic, since it has been clearly demonstrated that the psychological state and attitudes of employees affect production, absenteeism, and labor turnover. There is also a genuine interest of progressive management, and of unions, in the welfare and satisfaction of the employee. It might be held that unless there is genuine interest, a basic attitude of consideration and respect for the individual worker, satisfactory results will not be achieved, since employees will recognize the discrepancy between attitudes

and actions. Good supervision requires attitudes of respect, understanding, and consideration for the individual worker. A study by Ghiselli (12) concludes that "The most outstanding self-perception of the 'poor' supervisor is his sales approach to human relations," while "the good supervisor . . . sees himself as respecting the rights and dignity of others." Bass (5) found that those who believed in consideration for subordinates were later rated as successful supervisors, while there was no relation between later rated success and opinions favoring initiation of structure.

While in the area of supervision the understanding point of view has been increasingly accepted, in other areas of industry and industrial management the manipulative approach is more in evidence. In selection and placement, in grooming executives for promotion and advancement, management seeks to control and mold the lives of its employees, even extending its influence into their social and family lives. The nature and extent of this attempted influence is portrayed in a recent book by Whyte (52).

Shartle's study of leadership in administration (44) clearly illustrates the simultaneous operation of these two approaches to dealing with subordinates. A factor analysis of nine dimensions of leadership resulted in two major factors, which Shartle labels "initiating structure" and "consideration." They seem to reflect the manipulative and the understanding approaches, respectively. He identifies these two dimensions of leadership with the "get the work out" approach and the "human relations" approach. He points out their similarity to dimensions appearing in the classroom and in parent-child relationships (44, pp. 120-121). While the two dimensions may be viewed as complementary, with administrators using both in an integrated fashion, they are often in conflict.

Shartle writes that "Anyone who has been in a position of high leadership potential has experienced a conflict between the two dimensions. An executive knows that his superior and other persons of high influence expect him to produce. But he may regard

his staff highly and may be reluctant to put the pressure on them. This conflict may become so intense that he may even seek another position" (44, p. 125). Shartle also recognizes that this conflict exists in our society: "There seems to be a basic conflict in our ideology of leaders. We want persons in leadership roles, and yet we do not want to place limitations upon ourselves to submit to leadership" (44, p. 119). Shartle aligns himself with the consideration dimension, stating that it is his "point of view that manipulation runs counter to the ideals of a democratic society" (44, p. 111).

IN ADVERTISING AND PUBLIC RELATIONS

The greatest source of manipulation in our contemporary society is in the field of advertising and public relations. In recent years, changes have begun which raise some serious questions about the uses to which the understanding of people is being put. In the past, research and practice in marketing and public opinion has tended to be concerned with discovering the attitudes and opinions of the public as bases for advertising and sales campaigns. True, there has always been some attempt to create or change attitudes, desires, and wants. Recently this aspect of influencing consumers has been receiving increased emphasis. The fact that people are often moved to action more on the basis of emotion than reason has been known, and exploited, for a long time. The fact that these emotions operate without the awareness of the individual, and that they can be influenced without such awareness, has become the basis for much of the current attempt to influence consumers and public opinion.

Advertising has often been justified as a service to the consumer, in educating him to the availability, qualities, and usefulness of commodities for the satisfaction of his needs and wants. Appeals have been considered to be based upon the relative qualities of competing products, or the relative desirability of satisfying competing wants. The newer trend, however, doesn't appeal to the

rational bases of decisions or choices, but to the irrational impulses which have no relationship to the qualities or utility of the product being advertised. Psychology is thus used not to understand people and their needs, in order to satisfy those needs, but to apply this understanding *to control the behavior of people without their conscious or rational consent*. In other words, knowledge of the motivations and desires of human beings is used to manipulate them in conformity with the will and desires of the manipulators.

This movement has been designated as motivation research, or MR. A recent popular survey of this field is given by Packard. He details the "large scale efforts . . . being made, often with impressive success, to channel our nonthinking habits, our purchasing decisions, and our thought processes by the use of insights gleaned from psychiatry and the social sciences" (30, p. 3). He points out that "nothing is immune or sacred" (30, p. 5); the baser motives, anxieties, and weaknesses of people are played upon. So-called "social engineers" are using psychological knowledge and understanding to manipulate people into conforming to what the "engineers" consider desirable—ignoring the real needs of the individual—and calling the process "human engineering."

There is probably no doubt that the effectiveness of the techniques used is overrated, and that motivational research has been oversold. There is little, if any, research evidence of the validity of the claims of successful appeal to motivations. Much of the effort and activity is based on subjective or intuitive interpretations of results of so-called depth interviews or projective testing of small samples. And admittedly there are various reasons, some of them rational, for human behavior such as buying a particular product. But the methods used appear to be effective, even though the reasons may be wrong. Without research, advertising can easily and successfully appeal to emotional elements outside the consumer's awareness.

The most recent development in this field is the use of subliminal stimuli in movie and TV advertising. While there is again

no experimental evidence of its effectiveness, there is sufficient research in the psychology of perception to indicate its potential effectiveness (26).

ETHICAL IMPLICATIONS

The ethical and moral implications of such manipulation must therefore be considered (26). The potentiality of the methods in public relations and politics, suggested by Packard, are great, and of considerable significance. Packard quotes Kenneth Boulding as saying that "a world of unseen dictatorship is conceivable, still using the forms of democratic government" (30, p. 181).

Some of those engaged in the activity have some qualms about it. Packard quotes one as saying that "It may be said that to take advantage of a man's credulity, to exploit his misapprehensions, to capitalize on his ignorance, is morally reprehensible—and this may well be the case. . . . I do not know" (30, pp. 258–259). Packard raises some of the ethical questions, such as "When you are manipulating, when do you stop? Who is to fix the point at which manipulation becomes socially undesirable?" (30, p. 240). He suggests the need for a code of ethics in advertising and public relations to control manipulative efforts.

Some have sought to defend manipulation on the grounds that it is justified by the results. In the advertising field, the reasoning seems to be that increased consumption leads to increased production, with full employment and further increased consumption, resulting in prosperity, rising standards of living, and thus general happiness. But the results are not necessarily greater happiness psychologically, nor in some cases even materially. Particularly in the political field might this not be the case (42). Moreover, one might question whether the ends justify the means. The means involve the manipulation of human personality, and this manifests a disrespect for the individual, his rights, and his worth. Packard writes that "the most serious offense many of the depth manipulators commit, it seems to me, is that they try to invade the privacy

of our minds. It is this right to the privacy of our minds—privacy to be either rational or irrational—that I believe we must strive to protect” (30, p. 266). It would seem to be appropriate for those psychologists, sociologists, anthropologists, and other social scientists, who have given their support and services to these manipulators, to consider the consequences of their abetting the trend toward manipulation, and to examine their consciences regarding the desirability and morality of such activity. The frightful situation of thought control so vividly described by Orwell (29) doesn’t appear to be too fantastic in the light of the activities and goals of these manipulators of our attitudes and behavior in the fields of advertising, public relations, and particularly political campaigning.

MANIFESTATIONS IN PSYCHOLOGY AND PSYCHIATRY

Rogers (33) feels that the major trend in clinical psychology and psychiatry has been toward the manipulative point of view. Suggesting that it leads to a philosophy of social control by the few, he feels, however, that few psychologists or psychiatrists would agree with this end, though he quotes Skinner as one psychologist who does advocate a frank facing of the possibility and desirability of controlling human behavior. Skinner apparently believes that such control by psychologists is better than leaving it to “those who grasp it for selfish purposes: to advertisers, propagandists, demagogues, and the like” (45, p. 25). Rogers points up the implications of control even by psychologists or experts, in terms of the loss of independence by the individual.

Currently in the field of counseling and psychotherapy, the trend toward manipulation does not appear to the writer to be as strong as the trend toward the understanding approach. Gordon (14), however, seems to feel that at the present time the balance is still toward the manipulative approach. Bateson describes the changing conception of psychotherapy as follows:

The change toward larger Gestalten and the necessity of this change for

both humanistic and formal reasons can be illustrated by considering Sullivan's emphasis upon the phenomenon of interaction. This emphasis is very clearly part of a defense of man against the older, more mechanistic thinking which saw him so heavily determined by his internal psychological structure that he could easily be manipulated by pressing the appropriate buttons—a doctrine which made the therapeutic interview into a one-way process, with the patient in a relatively passive role. The Sullivanian doctrine places the therapeutic interview on a human level, defining it as a significant meeting between two human beings. The role of the therapist is no longer to be dehumanized in terms of definable purpose which he can plan, and the role of the patient is no longer dehumanized into that of an object of manipulation (40, p. 263).

Bateson feels that "by and large, psychiatrists have a permissive understanding" (40, p. 127). Sutich wrote in 1944: "It is evident that modern therapeutic and analytical principles have their roots in democratic principles. And it is equally evident that most American psychologists are committed to the support of democratic principles throughout the entire range of human behavior" (48). A recent volume on psychotherapy to which a number of outstanding contemporary psychotherapists contributed (10) seems to reflect a growing acceptance of the understanding approach; this appears to be the major theme of the contributions to the book.

Nevertheless, the manipulative approach is still much in evidence in counseling and psychotherapy. It is manifested by a lack of trust or confidence in the client to solve his own problems, to take responsibility for himself in the therapeutic process. It is characterized by activity on the part of the therapist, who takes responsibility for the treatment process, diagnosing and analyzing the client's problems and advancing solutions. There may be direct attempts to mold the client's attitudes, values, and behavior. There is an apparent assumption that the client is incapable of understanding himself and the complex psychological dynamics of his behavior. Rather, he needs an expert to explain, interpret, advise, teach, direct, persuade, even to exhort, inspire and preach. The

client is helpless, and dependent on the therapist, who is strong and wise and who knows best what is good for him.

In a recent series of addresses dedicating a new hospital in St. Louis, Saslow detected as one of the major themes the question of control of behavior, although only one speaker (Cobb) explicitly mentioned it. Saslow raises a question about the values of those who control behavior even in a therapeutic community setting, or of any professional persons who have within their power some means of modification and control of the behavior of persons they wish to influence. In the case of the use of tranquilizing drugs, for example, he asks: "Who will tranquilize whom? Under what circumstances? And for what purposes?" (43, p. 106).

It thus appears that we must question the use of methods of manipulation even in the hands of professional persons who presumably would use them for the good of those whom they manipulate. There is a question regarding the goals of such manipulation, even in the hands of professional persons. Essentially, it is this: is it desirable, or ethical, to manipulate anyone, for any purpose, or is this inimical to self-responsibility and self-determination, which appear to be increasingly recognized and accepted as desirable goals or values in our society?

Freud appears to have had a basic concept of the individual which would lead to a manipulative or controlling type of therapy (7, 14, 39, 50). Freud viewed man as basically bad, accepting essentially the doctrine of original sin, as Mayo (25, p. 158) points out. Life was viewed as a strenuous fight to control or to subdue perversion or pathological impulses. The individual was in constant conflict with society, and Freud identified himself with society. The therapist then would tend to be a controlling element. Nevertheless, though Freud was apparently rather authoritative in therapy, many other analysts in practice have not been particularly manipulative.

Attempts to shorten the traditional lengthy analysis have resulted in more activity and manipulation on the part of the thera-

pist, as exemplified by Alexander and French (2). A few other therapists have advocated active manipulation, e.g., Salter (41) and Herzberg (16). De Grazia (8) also would appear to sanction considerable manipulation on the part of the therapist, and the sector or limited therapy of Deutsch and Murphy (9) is relatively therapist controlled.

In the understanding approach in psychotherapy, emphasis is placed upon the capacity of the client for taking responsibility for himself, beginning with the therapeutic process itself. There is confidence that the client will make the best, or "right," choices for himself, without coercion, direction, or pressure of any kind. He can be trusted to make his own decisions. Dependence is placed upon the natural or inherent growth forces in the individual. The therapeutic situation is one in which an atmosphere is created in which these growth forces can be released and allowed to operate. Maslow expresses it well as follows: "The key concepts in the newer dynamic psychology are spontaneity, release, naturalness, self-acceptance, impulse awareness, gratification. They *used* to be control, inhibition, discipline, training, shaping, on the principle that the depths of human nature were dangerous, evil, predatory, and ravenous" (24, p. 352).

One might question whether the understanding approach is not basically manipulative. The object of any therapy is to change behavior, and thus to control it. But there is a difference in the meaning of control here. In the understanding relationship the nature and the extent of the change is under the complete control of the client. The therapist provides only the atmosphere, or the conditions, under which the client can change if he chooses to do so. In the understanding approach, the objective is to facilitate self-determined change.

Institutional care of the mentally ill has been characterized by the manipulative attitude. Custodial care has had as its objective the control of patients; drugs, physiotherapy, hydrotherapy, and shock, as well as conventional restraints, have been used as

methods of control. Recently, however, there has been progress toward the understanding approach (6, 15, 17, 47). Gilbert and Levinson (13) use the term "humanistic" to apply to the newly developing viewpoint. In this conception, the hospital is "a community of citizens rather than a rigidly codified institutional mold," and "the hospital members [are] persons rather than mere objects and agents of treatment." The hospital is conceived of as a therapeutic community, or a therapeutic social environment, existing for the patients rather than, as in many custodial institutions, for the staff. Gilbert and Levinson see the custodial orientation as autocratic with a rigid status hierarchy and a minimizing of communication. The humanistic orientation, on the other hand, attempts to democratize the hospital, increasing patient self-determination and opening channels of communication.

The fears of those who felt that giving patients freedom, treating them as persons rather than as objects, would result in a return of bedlam have not been realized. Instead, when patients have been given freedom and self-government or a voice in institutional management, they have shown themselves capable of accepting responsibilities. Rather than becoming agitated and violent, they have become less troublesome, less regressive. Stanton and Schwartz (47) report that incontinence and soiling practically disappeared from the hospital. The results of the humanistic or understanding approach, where it has been tried, have been little less than spectacular and probably no less effective than the tranquilizing drugs.

EVIDENCE OF EFFECTIVENESS OF UNDERSTANDING

While questions regarding the effectiveness of the understanding approach might be raised, there is evidence of its value where it has been used. The effectiveness of the manipulative approach seems to be clear—in certain situations and for certain purposes. It is effective in influencing behavior in directions desired by the manipulator, such as in advertising. We can, of course, raise ques-

tions regarding the desirability of such manipulation, both as regards its purposes and its means.

The understanding approach may be questioned as a technique for controlling or influencing people toward behavior desired by someone else. This, however, is not the purpose of the approach. As indicated above in the discussion of psychotherapy, its purpose is to make possible self-desired change in the individual. Actually, such changes, as in psychotherapy, are usually in directions desired by society as a whole.¹ One might question whether this approach is economical or efficient in initiating change in behavior; one is reminded of the old problem of the efficiency of democracy relative to an authoritarian government. Which is desirable depends on one's goals and values. Democracy is slow and inefficient in situations where immediate, specific action is required. So may be the understanding approach. It is difficult to think of an army being led in battle on this basis, for example. Yet, even in the military situation, this approach may be the most effective in building up an organization with high morale prior to action. To achieve its purpose, which is self-responsible behavior, no other method appears to be as effective.

We have already referred to some situations in which this approach has been effective in developing satisfaction and adjustment in the individual, as well as socially-desired behavior. The Western Electric study (25, 32) indicates its effectiveness in industry. Maier (23, pp. 7-10) refers to a number of studies which indicate that when groups participate in decision-making, with the point of view of each individual being recognized, understood, and considered, acceptance and satisfaction with the results is greater than where the decision is made outside the group. James Richards reports the effective use of group-centered leadership in an industrial situation in Gordon (14, ch. 12).

Morse and Reimer (27) report the results of two programs of decision-making in industry, one autonomous, the other hierarchi-

¹ See Chapter 4 for a discussion of individual versus social goals.

cally controlled. Worker satisfaction increased under the first, and decreased under the second. Productivity increased under both, though more under the second than under the first. Lewin (19) reports a study in which it was found that group discussion and decision resulted in greater changes in food habits than did a lecture. The experiments of Lewin and his students (20, 21, 22) on democratic and autocratic atmospheres indicate that groups function more constructively in a democratic situation. Similar results were found in a study of teachers' classroom behavior (3); and in the area of parent-child relationships a democratic family environment was found to be related to child adjustment (4). In the field of medicine and public health there is evidence for the effectiveness of this approach in helping the individual seek and accept treatment. The Peckham Experiment in London found that while direct medical advice is not usually followed, when the facts and their implications were simply presented without advice, action was taken in the overwhelming majority of cases (31; discussed in Rogers [34, pp. 59-60] and in Gordon [14, p. 35]). In psychotherapy there are no adequate data regarding the relative effectiveness of various approaches. But it appears that the understanding approach, as represented by client-centered therapy, is at least as effective as any other approach. The general opinion of therapists seems to be that an understanding approach leading to self-initiated change yields greater and more permanent changes in personality and behavior than does the manipulative approach.

Rogers, speaking of the understanding relationship, says "if the administrator, or military or industrial leader, creates such a climate within his organization, then his staff will become more self-responsible, more creative, better able to adapt to new problems, more basically coöperative. It appears possible to me that we are seeing the emergence of a new field of human relationships, in which we may specify that if certain attitudinal conditions exist, then certain definable changes will occur" (34).

THE PROBLEM OF CONTROL

Skinner (46), an experimental psychologist, raises some serious questions which deserve attention. Pointing out that control is the result of science, he states that "we have no guarantee that the power thus generated will be used for what appear to be the best interests of mankind. . . . A science doesn't contain within itself any means of controlling the use to which its contributions will be put. . . . Are we to continue to develop a science of behavior without regard to the use which will be made of it? If not, to whom is the control which it generates to be delegated? . . . There is good reason to fear those who are most apt to seize control" (46, pp. 437-438). He points out that to proclaim that man is a free agent is impossible—"we all control, and we are all controlled" (46, p. 438). Moreover, "to refuse to accept control . . . is merely to leave control in other hands" (46, p. 439). In psychotherapy, for example, the individual may be able to reach his own solution in a "good" society, but what if he is subject to all kinds of controls outside of therapy? The advantage of democracy over totalitarianism is that control is diversified in the former. "It is the inefficiency of diversified agencies which offers some guarantee against despotic use of power" (46, p. 440). Different sources of control cancel each other out, as it were. While the government may be assigned superior power, the problem of preventing its misuse remains. Skinner hopes, however, that "science may lead us to the design of a government, in the broadest possible sense, which will necessarily promote the well-being of those who are governed" (46, p. 443). He suggests freedom, security, happiness, and knowledge as conditions of a strong society. These conditions, he recognizes, involve moral or ethical issues. Yet, he continues, "If a science of behavior can discover those conditions of life which make for the ultimate strength of men, it may provide a set of 'moral values' which, because they are independent of the history and culture of any one group, may be generally accepted" (46, p. 445). By the "strength of men" he

appears to mean survival of the group or culture, but since the conditions for this survival cannot be predicted, we cannot discover the values that make for the "ultimate strength of men." Nor does Skinner answer the question of who should control. Who should control is determined by who *will* in the group which survives.

Skinner, therefore, has no solution to the problem of control. He does not propose that scientists should control. But control exists. "Western thought has emphasized the importance of the individual. . . . The use of such concepts as individual freedom, initiative, and responsibility has . . . been well reinforced" (46, pp. 446-447). But "The hypothesis that man is not free is essential to the application of the scientific method to the study of human behavior. The free inner man who is held responsible for the behavior of the external biological organism is only a prescientific substitute for the kinds of causes which are discovered in the course of scientific analysis. All these alternative causes lie outside the individual" (46, pp. 446-448). As Ruesch and Bateson (40, p. 216) put it, ". . . in regard to the Pavlovian subject we may now state that he will learn to expect a world in which he has no control over the good and evil which may befall him." Thus behavior theory, as well as Freudian psychology, with their mechanistic concept of determinism, leave no place for individual choice and therefore responsibility. Mowrer (28), disturbed by this lack of responsibility, appears to be repudiating behavioral psychology.

So we have no solution to the problem of control, says Skinner. Man is not a free agent, and has no control over his own behavior, which is determined from without. Skinner has returned to the stimulus response behaviorism of Watson. He describes three links in the chain of behavior: (1) an operation performed upon the organism from without; (2) an inner condition; and (3) a kind of behavior. The second link is not essential for the control of behavior. "The objection to inner states is not that they do not exist, but that they are not relevant in a functional analysis. . . .

Unless there is a weak spot in our causal chain so that the second link is not lawfully determined by the first, or the third by the second, then the first and third must be lawfully related" (46, p. 35). Indeed, there is a weak spot in the chain; the second link is not determined solely by the first, but is influenced by other factors and conditions within the organism which affect the perception, definition, and interpretation of the stimulus, except perhaps in simple reflex acts. This factor accounts for what is referred to as the freedom of the individual, or free will. While it is true that all behavior is determined, the individual often experiences the sense of choice. This experience is a fact, which must be considered because of its influence on the individual's attitudes and behavior. Skinner states that "science is a willingness to accept facts even when they are opposed to wishes" (46, p. 13). But what are "facts"? What is truth, or knowledge? Behavior is not determined by objective stimuli, but by the perceptions of the world by the individual. "Man lives essentially in his own personal and subjective world . . . though there may well be such a thing as objective truth, I can never know it; all I can know is that some statements appear to me subjectively to have the qualifications of objective truth. Thus there is no such thing as scientific knowledge; there are only individual perceptions of what appears to each person to be such knowledge" (36, pp. 10-11).²

Bateson presents a similar statement, with the added concept that belief in one's perceptions (or values) constitutes validity.

The definition of a relationship depends not merely upon the skeleton of events which make up the interaction but also upon the way the individuals concerned see and interpret these events. Thus seeing or interpreting can be regarded as the application of a set of propositions about the world or the self whose validity depends upon the subject's belief in them. The individuals are partially free to interpret their world according to the premises of their respective character structure, and their freedom to do this is still further increased by the phenomena of selective awareness and by the fact that the perceiving individual plays a part in creating the ap-

² See also in this connection footnote 1 in Chapter 7 and Chapter 11. For a further discussion of control in another context, see Chapter 12.

propriate sequences of action by contributing his own action to the sequence (40, pp. 220-221).

Thus, the concepts of individual freedom, initiative, and responsibility are experienced, and are therefore facts; moreover, they are held to be values by a large part, if not the majority, of mankind. If accepted as such, then we are justified in attempting to preserve them, and in resisting the encroachment of control from the outside, whether or not it is for the presumed good of the individual.

The concept of control, as used by Skinner, covers several different things. He appears to include the determination or influencing of behavior by physical factors of the environment, by other individuals, by groups of individuals, and by agencies such as the government. Used in this sense, control is inevitable. Some control is no doubt necessary and desirable in order to prevent anarchy. For, although man may be fundamentally good, many men have been corrupted by the imperfect society in which we live; and even in a more perfect society, some men would no doubt have some antisocial impulses. Such control as is necessary or desirable is only for the purpose of protecting the legitimate freedom of the individual from being infringed upon by the unwarranted freedom of others. The control is of the environment, to assure that it makes possible the maximum freedom and initiative of individuals. As to who should exercise this control, it would seem that we have no better alternative than to vest it in the elected representatives of a free people, whether their choices are, in essence, determined in the sense that they are not capricious.

If we accept as values or goals of life the independence, freedom, initiative, and spontaneity of the individual, then we must prevent encroachment on these by the manipulative activities of others. If these concepts be illusory, we are still justified in preserving them, as long as they are values. And it might well be that these are the moral values which are independent of history and

culture, and which constitute the "strength of men" which will assure the survival of our society.

In this chapter we have distinguished two major, and opposed, approaches to human relations—designated as the understanding and the manipulative approaches. Both are present, in varying degrees, in every field of human relations. Each is dominant in one or more fields, e.g., understanding in counseling and psychotherapy, manipulation in advertising and public relations.

The manipulative approach creates certain problems in terms of the ethics of controlling human behavior. The apparent snowballing of the manipulative approach in advertising and public relations, and its entrance into politics, raise some real concern about the future, with specters of the horrors of Orwell's *Nineteen eighty-four*. The implications should be considered seriously by all students of human behavior who are concerned about the freedom of the individual. Some control apparently is necessary, and we have indicated its place in society. We do not pretend to have dealt with the problems of control at all adequately, however. Rogers and Skinner (39) present a stimulating discussion of this problem.

Our main concern here is with counseling and psychotherapy. Understanding, rather than control, should characterize counseling and psychotherapy; and the understanding approach seems to be well entrenched in this field, though not universally applied or carried to its logical extreme. It is consistent with, and indeed the expression of, the ethical principles and philosophy of counseling touched upon in Chapters 3 and 4. The ultimate expression of this approach is client-centered therapy, and in the next chapter this point of view will be developed further. In a later chapter we shall consider the implications of this choice for psychotherapy as a scientific procedure.

REFERENCES

1. Adelson, J. Freud in America: some observations. *Amer. Psychologist*, 1956, 11:467-470.

2. Alexander, F., & French, T. M. *Psychoanalytic therapy*. New York: Ronald, 1946.
3. Anderson, H. H., & Brewer, J. Studies of teachers' classroom personalities: I. *Appl. Psychol. Monogr.*, 1945, No. 16.
4. Baldwin, A. L., Kalhorn, Joan, & Breese, Fay. Patterns of parent behavior. *Psychol. Monogr.*, 1945, 54, No. 3.
5. Bass, B. M. Leadership opinions as forecasts of supervisory success. *J. appl. Psychol.*, 1956, 40:343-346.
6. Belknap, I. *Human problems of a state mental hospital*. New York: McGraw-Hill, 1956.
7. Bruner, J. S. Freud and the image of man. *Amer. Psychologist*, 1956, 11:463-466.
8. De Grazia, S. *Errors of psychotherapy*. Garden City, New York: Doubleday, 1952.
9. Deutsch, F., & Murphy, W. F. *The clinical interview. Vol. Two: Therapy*. New York: International Universities Press, 1955.
10. Fromm-Reichmann, Frieda, & Moreno, J. L. (Eds.) *Progress in psychotherapy: 1956*. New York: Grune & Stratton, 1956.
11. Gellhorn, W. *Individual freedom and governmental restraints*. Baton Rouge: Louisiana State University Press, 1956.
12. Ghiselli, E. E. Role perceptions of successful and unsuccessful supervisors. *J. appl. Psychol.*, 1956, 40:241-244.
13. Gilbert, Doris C., & Levinson, D. J. Ideology, personality, and institutional policy. *J. abnorm. soc. Psychol.*, 1956, 53:263-271.
14. Gordon, T. *Group-centered leadership*. Boston: Houghton Mifflin, 1955.
15. Greenblatt, M., York, R. H., & Brown, Esther L. *From custodial to therapeutic patient care in mental hospitals*. New York: Russell Sage Foundation, 1955.
16. Herzberg, A. *Active psychotherapy*. New York: Grune & Stratton, 1945.
17. Jones, M. *The therapeutic community*. New York: Basic Books, 1953.
18. Leighton, A. H. *The governing of men*. Princeton: Princeton University Press, 1944.
19. Lewin, K. Group decision and social change. In T. M. Newcomb & E. L. Hartley (Eds.), *Readings in social psychology*. New York: Holt, 1947.
20. Lewin, K., Lippitt, R., & White, R. K. Patterns of aggressive behavior in experimentally created social climates. *J. soc. Psychol.*, 1939, 10: 271-299.
21. Lippitt, R. An experimental study of the effect of democratic and authoritarian group atmospheres. *Univer. Iowa Stud. Child Welf.*, 1940, 16:43-195.

22. Lippitt, R., & White, R. K. An experimental study of leadership and group life. In T. M. Newcomb & E. L. Hartley (Eds.), *Readings in social psychology*. New York: Holt, 1947.
23. Maier, N. R. F. *Principles of human relations: applications to management*. New York: Wiley, 1952.
24. Maslow, A. H. *Motivation and personality*. New York: Harper, 1954.
25. Mayo, E. *The human problems of an industrial civilization*. New York: Macmillan, 1933.
26. McConnell, J. V., Cutler, R. L., & McNeil, E. B. Subliminal stimulation: an overview. *Amer. Psychologist*, 1958, 13:229-242.
27. Morse, Nancy C., & Reimer, E. The experimental change of a major organizational variable. *J. abnorm. soc. Psychol.*, 1956, 52:120-129.
28. Mowrer, O. H. Some philosophical problems in psychological counseling. *J. counsel. Psychol.*, 1957, 4:103-111.
29. Orwell, G. *Nineteen eighty-four*. New York: Harcourt, Brace, 1949.
30. Packard, V. *The hidden persuaders*. New York: David McKay, 1957.
31. Pearce, I. H., & Williams G. S. *Biologists in search of material*. London: Faber & Faber, 1938.
32. Roethlisberger, F. J., & Dickson, W. J. *Management and the worker*. Cambridge, Mass.: Harvard University Press, 1939.
33. Rogers, C. R. Divergent trends in methods of improving adjustment. *Harvard educ. Rev.*, 1948, 18:209-219.
34. Rogers, C. R. *Client-centered therapy*. Boston: Houghton Mifflin, 1951.
35. Rogers, C. R. *Becoming a person*. Austin: The Hogg Foundation for Mental Hygiene, University of Texas, 1956.
36. Rogers, C. R. *A theory of therapy, personality, and interpersonal relationships as developed in the client-centered framework*. Chicago, 1956. (Mimeographed.)
37. Rogers, C. R. Implications of recent advances in prediction and control. *Teach. Coll. Rec.*, 1956, 57:316-322.
38. Rogers, C. R. A note on "The nature of man." *J. counsel. Psychol.*, 1957, 4:199-203.
39. Rogers, C. R., & Skinner, B. F. Some issues concerning the control of human behavior. A symposium. *Science*, 1956, 124:1057-1066.
40. Ruesch, J., & Bateson, G. *Communication: the social matrix of psychiatry*. New York: Norton, 1951.
41. Salter, A. *Conditioned reflex therapy*. New York: Creative Age Press, 1949.
42. Sargent, W. *Battle for the mind*. Garden City, New York: Doubleday, 1957.
43. Saslow, G. Major themes. In *Theory and treatment of the psychoses: some newer aspects*. Papers presented at the dedication of the Renard

- Hospital, St. Louis, October, 1955. St. Louis: Washington University Press, 1956.
44. Shartle, C. L. *Executive performance and leadership*. Englewood Cliffs, N.J.: Prentice-Hall, 1956.
 45. Skinner, B. F. Experimental psychology. In W. Dennis (Ed.), *Current trends in psychology*. Pittsburgh: University of Pittsburgh Press, 1947.
 46. Skinner, B. F. *Science and human behavior*. New York: Macmillan, 1953.
 47. Stanton, A. H., & Schwartz, M. S. *The mental hospital*. New York: Basic Books, 1954.
 48. Sutich, A. Toward a professional code of ethics for counseling psychologists. *J. abnorm. soc. Psychol.*, 1944, 39:329-350.
 49. Thomas, L. G. *The occupational structure and education*. Englewood Cliffs, N.J.: Prentice-Hall, 1956.
 50. Walker, D. E. Carl Rogers and the nature of man. *J. counsel. Psychol.*, 1956, 3:89-92.
 51. Weinberg, S. K. *Society and personality disorders*. New York: Prentice-Hall, 1952.
 52. Whyte, W. H., Jr. *The organization man*. Garden City, New York: Doubleday, 1956.

CHAPTER 7

A Systematic View of Counseling and Psychotherapy

In the preface it was stated that the bias of this book was toward developing and using a systematic approach in counseling and psychotherapy. In the preceding chapters a basis has been laid for a systematic point of view. In this chapter we shall develop this point of view preparatory to discussing its application.

Not everyone agrees that a systematic approach to counseling is necessary or desirable. Many practitioners and a number of writers prefer and advocate an eclectic approach. We shall now review some of the arguments for and against eclecticism, state those for a systematic approach, and develop the latter.

ECLECTICISM

The eclectic approach professes to appropriate and use the best from the various systematic approaches. It is contended that no single systematic method of counseling is complete or adequate in all situations. Therefore no counselor should limit himself to a single approach, but be willing to accept the best from all of them. Symonds expresses this point of view as follows: "It is my belief that the psychotherapist must be a versatile person who adapts his procedures to the demands of the client with whom he is working. I have taken the point of view that there is merit in the different

psychotherapeutic theories and that each school of thought is making an important contribution" (35, pp. viii-ix).

Perhaps one of the best statements of this point of view is made by Williamson:

Counseling . . . may be thought of as embracing a wide variety of techniques, from which repertoire the effective counselor selects . . . those which are relevant and appropriate to the nature of the client's problem and to other features of the situation. . . . Each technique is applicable only to particular problems and particular students. There are no general techniques but rather particularized procedures to be used *only* if the student has a problem for which those procedures are appropriate. . . . Techniques are specific to different problems and to different students. The effective counselor avoids stereotyped and indiscriminate counseling. Rather, the counselor adapts his specific techniques to the individuality and problem pattern of the student, making the necessary modifications to produce the desired result for a particular student. For purposes of exposition and training, we speak of general and of standard techniques, but in clinical practice, flexibility, adaptation, and modification are characteristic of the counselor's application of general procedures to a particular student (39, pp. 219-220).

It must be noted that Williamson does not consider this approach to be eclectic, since he conceives of eclecticism as consisting of parts "fused and interwoven into a unitary concept" (39, p. 220). Nevertheless, his statement appears to represent what is generally accepted as the eclectic approach.

Such an approach has an intellectual, even a scientific appeal. The selection of the best from several systems certainly seems justifiable and desirable. The attention to individual differences and the recognition of different problems and problem situations seem to be commendable. All counselors are keenly aware of these differences in their clients, and the science of psychology has been greatly concerned with the study of individual differences. It thus would appear to be desirable to take these into consideration in counseling. It seems logical that they should lead to the application of different techniques appropriate to the individual client.

But there are several criticisms which may be raised regarding

the eclectic approach. The first is that emphasis is upon techniques in counseling, rather than upon the attitudes and feelings of the counselor, which have recently been increasingly recognized as a highly significant, if not the most significant, aspect of the counseling relationship. Second, and related to this stressing of techniques, the approach seems to be clearly and highly manipulative. This aspect is evident in Williamson's statement, above, and is abundantly supported by his whole treatment of counseling. Third, nowhere is there to be found adequate information on criteria regarding what techniques to use when, with what clients. An exception to this statement is perhaps Thorne's book (36) which, however, seems not to have won much acceptance.

Williamson has little to say concerning the specifications for use of various techniques. He writes that "it is . . . assumed that an inappropriate technique will not be chosen for use" (39, p. 220). Yet, "the counselor recognizes that dependable evidence is lacking which would establish a particular technique as a certain producer of desirable adjustment. Rather, the counselor has knowledge of certain techniques which produced certain results in a similar case; therefore, he tries them out with appropriate modifications. If they prove to be ineffective, he suggests something else and continues this trial and rejection until he finds something which 'clicks' with the student. . . . Counseling is still in the trial-and-error stage of treatment" (39, p. 221). This trial-and-error approach to counseling is, of course, far removed from a scientific concept of counseling. Instead of a repertoire of techniques, the resources of an eclectic counselor have sometimes been referred to as a closet, or bag, of tricks. The terms "tools," "techniques," and "instruments" of counseling carry some of this connotation, as well as an inference of manipulation.

Fourth, such an approach develops no general principles of counseling. Indeed, it assumes that there are or can be none. While it might be maintained that the present state of psychology provides no adequate or established principles of behavior, there is

sufficient knowledge available to make certain tentative generalizations, or state certain hypotheses, as a basis for dealing therapeutically with human beings. Psychoanalysis is built upon one such hypothetical system of human behavior. Some therapists of the eclectic persuasion apparently do recognize the desirability of some theory or hypothesis as a basis for integrating discrete techniques. Unlike Williamson, some eclecticists have attempted to relate specific techniques to some theory of behavior. Symonds, for example, says: "It has been my purpose to integrate these diverse points of view into a consistent and unified approach" (35, p. ix). However, such attempts, including that of Thorne (36), have not resulted in any convincing approach to human behavior. They tend to consist of a system of empirical or intuitive statements of appropriate uses of various techniques loosely held together, if at all, by broad generalizations.

Rogers (23, p. 8) feels that attempts to reconcile different systems or schools of thought lead to a "superficial eclecticism." "This confused eclecticism," he writes, "has blocked scientific progress in the field" of psychotherapy. "Actually, it is only by acting *consistently* upon a well-selected hypothesis that its elements of truth and untruth can become known" (23, p. 24). Henle (11), in her discussion of eclecticism in psychology, takes a similar position, stating that the eclectic gives up the advantages of theory in the discovery of new facts. She also questions the efficiency of eclecticism in ordering the available facts, suggesting that it is not always internally consistent. Snygg and Combs make a similar point: "An eclectic system leads directly to inconsistency and contradiction, for techniques derived from conflicting frames of reference are bound to be conflicting" (32, p. 282). Hilgard (12) writes that "When there is no effort to be systematic, problems are not sharply defined. When problems are not sharply defined, anecdotal evidence is used loosely, and sometimes irresponsibly. A consequence is that very little evidence of an experimental sort is introduced." Conant similarly writes that

"The history of science demonstrates beyond a doubt that the really revolutionary and significant advances come not from empiricism but from new theories. . . . The trial-and-error procedures of pure empiricism are slow and wasteful" (5, pp. 30, 75).

It should be apparent that, with no general principles, the application of an eclectic approach in counseling is exceedingly difficult. As Williamson indicates, each counselor must learn by trial-and-error or experience. It also should be apparent that such an approach is therefore unteachable. The student cannot be taught when to use which techniques if no one knows what are the indications and contraindications for each. And even if such lists could be developed, learning then becomes a matter of memorizing a vast number of specific techniques and conditions. With no guiding principles, this becomes a difficult task. Even supervised experience in counseling becomes difficult with no such principles. Contrary to Arbuckle's statement (1) that eclecticism is the easiest approach, it actually becomes the most difficult method of all since there are no guides.

A SYSTEMATIC APPROACH

In contrast to an eclectic approach, a systematic point of view is based on general principles. These general principles are related to or derived from a theory of behavior, or certain assumptions and hypotheses regarding human behavior. Such an approach becomes therefore more easily applicable, and more easily taught and learned than an eclectic approach.

As Snygg and Combs point out: "Most of the therapeutic methods in current use, with the possible exception of psychoanalysis and, more recently, non-directive therapy, have little or no consistent theoretical framework for the practices they encompass. . . . Without a consistent theoretical framework, however, the therapist is reduced to sheer trial-and-error operation" (32, p. 281). Of the two major or existing systematic approaches to coun-

seling and psychotherapy, this book presents the client-centered approach—for several reasons. The basic reason no doubt is the writer's preference for this approach. But this preference, it is believed, is based on rational as well as emotional factors. While not thoroughly trained in psychoanalysis, he has had enough training and familiarity in it to feel able to evaluate it in comparison with client-centered therapy.

The client-centered method of psychotherapy is without question easier to teach and to learn than psychoanalysis. It is a much simpler system, and in this respect has the support of the law of parsimony. Also, it is more in keeping with the understanding approach to human relationships, while psychoanalysis seems to be more manipulative. The greater dependence on the client is a factor in the ease of learning the method, and it also is related to a third advantage over psychoanalysis: it appears to be much safer for an inexperienced therapist to use. While proponents of the client-centered method have been so cautious about their claims regarding the type of clients who can be helped that the method is widely held to be greatly restricted in usefulness, it has nevertheless been used successfully with a wide variety of clients presenting all degrees of severity of problems. A fourth reason for selecting it, then, is the belief that it is as widely applicable as psychoanalysis. Its success with a wide variety of clients suggests that it possesses the essential elements required for the process of therapeutic change. There is thus the belief that it incorporates, in their basic form, the necessary and sufficient conditions for psychotherapy. A fifth reason is that it is an expression of the phenomenological point of view, which is probably the most fruitful approach to understanding human behavior. This approach represents a developing trend in psychology. The acceptance of phenomenology in the physical sciences will perhaps make it respectable and hasten its acceptance by psychology.¹

¹ Wiener, in *"The human use of human beings,"* writes that the contributions of Gibbs and Einstein "represent a shift in the point of view of physics in which the

The theory of human behavior upon which client-centered therapy is based is by no means completely developed. The theory has been in process of development during the past several years, mainly by Rogers and his associates (22, 24, 25, 26). Probably no two therapists of this school would be in complete agreement with all the details of the theory, although there might be agreement with the phenomenological basis of the theory. This approach to human behavior is perhaps best developed by Snygg and Combs (31, 32, 33), though others (2, 14, 17) have contributed; Hallowell (9, ch. 4) gives a succinct treatment from the anthropological standpoint.

Some of the assumptions and hypotheses underlying client-centered therapy have been mentioned in the preceding chapters. A detailed presentation of the client-centered viewpoint is beyond the scope of this book. We shall present only the broad outline of a theory, attempting to tie it in with previous discussions of values and cultural influences on personality.

1. *The primacy of the self.* MacLeod (17), in his discussion of phenomenology in social psychology, emphasizes "the self as phenomenal datum." There is evidence that, after half a century of relative neglect of the self by psychology, it is being increasingly recognized as a significant factor in human behavior. Texts in social psychology are giving increasing emphasis to the self. Newcomb (19, p. 237) refers to "one's self as a value—a supreme value," and Krech and Crutchfield (15, p. 52) write that "in connection with self-regard some of the most potent demands and needs of the individual develop." Hilgard (12) recognizes the "self of awareness as an object of value." The phenomenological and client-centered point of view goes beyond this in postulating

world as it actually exists is replaced in some sense or other by the world as it happens to be observed, and the old naive realism of physics gives way to something on which Bishop Berkeley might have smiled with pleasure" (38, p. 20). See also Conant (5, ch. 2). Similarly, Brain (4), a physiologist, writes: "The perceptual world is not identical with the physical world, but is a representation of it. The perceptual world is a construction of the brain of each individual and is private to him." See Chapter 11 for further discussion.

the concept of the self as the highest or supreme value of the individual, and therefore the basic or primary datum for the understanding of human behavior. The central place accorded the self in this theory has led to its designation by some as self-theory.

2. *The self as a social product.* Hilgard (12) writes: "Once we reject the self as the unfolding of an inevitable pattern, but see it instead as an individual acquisition, we are impressed by the part which other people play in the shaping of an individual self." The self is a product of social experience, the result of the behavior of others toward the individual. The process by which the self develops was briefly described in Chapter 5. The self develops out of social interaction, and the individual's self-concept is his own definition of his relationship to the world about him. The human infant or child is impressionable, and, as pointed out in Chapter 5, is prone to accept the evaluations of himself held by those about him, particularly the "significant others" in his environment (32, pp. 82-83).

Culture provides the basic orientations with regard to the self, constituting what Hallowell (9, p. 87) calls the "culturally constituted behavioral environment," by which he means the environment as seen by the individual. It has already been indicated (Chapter 5) that the culture supplies the values, ideals, and standards for the individual, thus providing a "normative orientation." "Without normative orientation, self-awareness in man could not function in one of its most characteristic forms—self-appraisal of conduct. For the individual would have no standard by which to judge his own acts or those of others. . . . The outcome is, in turn, related to attitudes of self-esteem or self-respect and to the appraisals of others. . . . Self-evaluation through culturally recognized norms is inescapable" (9, pp. 105-106). This concept will be seen to be related to the superego of psychoanalysis, but it avoids the reification element in the superego concept. We noted above that the appraisal of the self, particularly during the forma-

tive stages of the self-concept in the child, is greatly influenced by the attitudes of the significant adults in his environment.

3. *Communication as the significant vehicle for the development of the self-concept.* It is apparent that the attitudes and evaluations of others toward the individual must be communicated to be effective. Communication is the basis of interpersonal relations. Communication requires the ability to take the role of another. When one does this, the self becomes an object, or a concept, to the individual, and self-awareness develops. Continually communicating with others, and thus seeing oneself as others see one, keeps the self-concept in line with social reality. Lack of communication results in the loss of this personality check, and the self-concept may become rigid. "The ability to perceive the difference between the self that the situation requires," and the self-concept, which is dependent upon the ability to see oneself as others see one, is essential for adaptive changes in the self-concept (32, p. 93). The ability to take the roles of others makes possible what communication theory designates as feedback (38). Feedback is the perception of the effects of one's behavior on others, and is the basis for changing one's behavior in order to bring it into accord with the situation. "Feedback of information thus becomes a steering device upon which learning and correction of errors and misunderstandings are based" (38, p. 7).

Difficulties or defects in communication have been noted in personality disturbances since at least the time of Janet (13), and are presently receiving considerable attention. Helfand (10) reports a study of the role-taking of schizophrenics, nonpsychotic patients, and normals. Chronic schizophrenics were found to be impaired in role-taking ability. They and the nonpsychotic patients, the latter while showing sensitivity to others, responded to others in a highly idiosyncratic manner. Defects in or lack of communication result in isolation. It would thus appear that isolation is the result rather than the cause of personality disturbances. Ruesch and Kees state that "Through unfavorable childhood experiences

these people (the mentally sick) failed to learn communication successfully and to share certain ways of denotation with others; as a result they became lonely, deviant, and marginal" (27, p. 10). However, isolation may lead to defects in communication and possibly result in personality disturbances (see Chapter 5).

4. *The self-concept as the basis of motivation.* Attempts to list and to order in a hierarchy human needs and drives have met with spectacular lack of success. The reduction of human needs to a single basic drive would be a boon to psychology, and to all those who are concerned with human relationships. Freud apparently realized this in his unsuccessful attempt to reduce all motives to the sex drive. If all human beings are motivated by a single basic need, then we do not need to be concerned about trying to isolate unique motives in clients for psychotherapy. Then it would be logical to use a single, common approach to all clients.

The phenomenological point of view provides this opportunity. We have stated that the self is the highest value of the individual. If this is so, then it would only be reasonable to recognize that "The basic human need (is) the preservation and enhancement of the . . . self. From birth to death the defense of the phenomenal self is the most pressing, most crucial, if not the only task of existence" (32, p. 58).² All behavior can be understood in reference to this basic need. There is no necessity for a list of needs in hierarchical order, or for worrying about the prepotency of various needs, as does Maslow (18). Maslow includes as one of his needs the need for self-actualization, but it is not clear just where he places it in his hierarchy. In one list (18, ch. 5) it is the fifth of seven or eight needs. Maslow limits this need to self-fulfillment of potentiality, and includes the esteem needs as a separate category just above the self-actualization need. However, he speaks of self-actualization as the "ultimate need" (18, p. 116). He also states

² Dobzhansky, a biologist, referring to the process of evolution, uses strikingly similar terminology: "The struggle seems to serve a noble purpose, which is the maintenance and improvement of the adaptation that the organism has made to its environment" (6, p. 59).

that "a healthy man is primarily motivated by his needs to develop and actualize his fullest potentialities and capacities" (18, p. 105). His discussion of self-actualizing people (18, ch. 12) accepts self-actualization as the criterion of health and normality, and thus apparently accords it primary status. This confusion is only one of the difficulties of attempting to develop a hierarchical classification of needs and to establish prepotency orders.

The need for the preservation and enhancement of the self subsumes all other needs, physiological and psychological. Other needs, desires, and wants are expressions of or means to the end of self-preservation and self-enhancement.³ Acceptance of this need as primary does away with apparent inconsistencies or irrationalities in behavior. Suicide, such as Hari-kari, is understandable, since self-respect is more important than physical survival. The development and maintenance of esteem—self-esteem and the esteem of others—is the motivation of human behavior.

Goldstein (8) uses the term self-actualization to describe this basic tendency or need. The drive toward health, or toward positive growth, assumed in client-centered therapy is an expression of this basic need. Newcomb (19, p. 328) refers to the ego as "the self as a value to be protected and enhanced." Other writers have used other terms: Lecky's self-consistency or self-organization refers to a similar concept. He regards all behavior as "the effort to maintain this organization" (16, p. 77). He further writes: "We assume . . . that every organism, as long as it remains alive, is continuously active, and hence continuously purposive. . . . We do not have to explain why an organism acts, but only why it acts in one way rather than another. . . . Any theory which is erected on the basis of this principle of unified action . . . and any technique derived from the theory for clinical use, is automatically prohibited from assuming a plurality of purposes. One source of

³ Rogers (24, pp. 17-18) distinguishes between the general tendency toward actualizing the organism, and a tendency toward self-actualization, which may be in conflict, or incongruent, with each other.

motivation only, the necessity to maintain that unity of the system, must serve as the universal dynamic principle" (16, pp. 80-81).

5. *Personality disturbance as the result of threat to the self-concept.* The self-concept is central in the personality, so it is only natural that if the self-concept is disturbed, the personality reflects this disturbance. The self-concept becomes disturbed when the maintenance or enhancement of the self is frustrated or threatened. Frustration of or threat to the satisfaction of the basic need of the individual results in a lowered evaluation of oneself, a loss of self-esteem, a reduced self-regard. Hilgard (12) notes that "some positive rather than negative evaluation of the self is one of the conditions necessary for normal psychological adjustment."

An organism or individual under threat becomes defensive, withdraws, and restricts or narrows its range of activity. "Threat is the individual's awareness of menace to his phenomenal self" (32, p. 118). "Under threat the impulse of the organism is to protect its organization and its concepts become more strongly defended than ever" (32, p. 91). "A self under threat has no choice but to defend itself in one form or another" (32, p. 135). It may attempt to overcome the threat, avoid the threat, or if neither one of these methods is successful, it may distort or deny the threatening situation. Snycg and Combs (32, ch. 8) and Hilgard (12) have pointed out that the common defense mechanisms described by psychoanalysis are means of dealing with threats. "All the mechanisms imply a self-reference, and . . . are not understandable unless we adopt a concept of the self" (12). Mechanisms may also be seen as bolstering self-esteem through self-deception. "The need for self-deception arises because of a more fundamental need to maintain or restore self-esteem" (12).

Deprivation and conflict have long been associated with personality disturbance. But deprivation and conflict do not result in disturbance unless the self-concept is involved. Maslow (18, p. 156) makes this point clearly in making a "distinction between a deprivation that is unimportant to the organism (easily substituted

for, with few serious after effects) and, on the other hand, a deprivation that is at the same time a threat to the personality, that is, to the life goals of the individual, to his defensive system, to his self-esteem, to his self-actualization, i.e., to his basic needs. . . . Only a *threatening* deprivation has the multitude of effects (usually undesirable) that are commonly attributed to frustration in general." The frustration or deprivation of biological needs are not necessarily, or even usually, a source of psychological threat or personality disturbance. "Deprivation is not psychopathogenic; threat is" (18, p. 158). Conflict, also, is pathogenic only when it involves threat to the self, as when a choice involves the giving up of a necessary goal or satisfaction related to the esteem needs. "It is possible to subsume most individual instances of threat under the rubric 'inhibiting or threatening-to-inhibit development toward ultimate self-actualization' as Goldstein has done" (18, p. 166).

Emotional or personality disturbances have, then, a common characteristic—a loss of self-esteem. This is a conclusion which seems to have been reached by a number of psychologists, apparently independently. A recent expression of this point of view is that of Stanton in a discussion of the influence of the therapeutic environment in mental illness. "The non-specific therapeutic measures rest upon the assumption that there are common factors in all serious functional illness. This assumption seems well founded at least from the point of view of modern psychoanalytic formulations. All patients are believed to retain throughout their illness an area of intact functioning which was ignored only a few years ago. At the same time, all patients are thought to suffer from *low self-esteem*" (34, p. 38). White (37) throughout his book stresses the significance of self-esteem for an ordered or normal personality. Maslow (18, pp. 166–167) summarizes his discussion of psychopathogenesis and the theory of threat under the heading of "Illness as Unitary" as follows: "What we have implied is that all or most illnesses come from this single source; i.e., psychopathogenesis seems to be unitary rather than multiple. Where then

do separate syndromes of illness come from? Perhaps not only pathogenesis but also psychopathology may be unitary. Perhaps what we now speak of as separate disease entities on the medical model are actually superficial and idiosyncratic reactions to a deeper general illness, as Horney claimed.”⁴

6. *Psychotherapy, therefore, must be directed toward the development of an adequate self-concept.* The development, or restoration, of self-esteem is the aim of psychotherapy. This is the basis for according respect to the individual in client-centered therapy. In phenomenological terms, “Therapy is the provision of a facilitating situation wherein the normal drive of the organism for maintenance or enhancement of organization is freed to operate. . . . The provision of experience whereby the individual is enabled to make more adequate differentiation of the phenomenal self and its relationship to external reality” (32, pp. 284–285).

Since threat to the self-concept is inimical to change in the self, psychotherapy must provide a situation in which the individual is free from threat. Threat narrows and restricts behavior, making the solution of problems more difficult. The accepting, nonjudgmental attitude of the therapist assists in providing a nonthreatening situation.

The client must learn, or recover, the ability to communicate with others, to take the role of others and see himself as others see him, before he can change himself. Freedom from threat makes possible the beginning of this process. The feeling that he is understood by the therapist, and, being understood for what he actually is, is still accepted, assists in this process.

If the client is to develop self-respect, or self-esteem, more than this is necessary, however. The client must experience more than acceptance. Understanding goes deeper than acceptance. It is a powerful force in human relationships. Its effect, even in a relationship definitely antitherapeutic by our standards, is suggested

⁴ See Chapter 10 for further discussion of the unitary nature of emotional disturbances.

by Orwell (20): The hero, Winston, is being tortured by his inquisitor, O'Brien, who is attempting to teach him to think as the Inner Party members do. In spite of the suffering inflicted upon him by O'Brien in the process, Winston does not hate him, but feels love for him. Winston's thoughts are described by Orwell:

It did not matter whether O'Brien was a friend or an enemy . . . O'Brien was a person who could be talked to. Perhaps one did not want to be loved so much as to be understood. O'Brien had tortured him to the edge of lunacy, and in a little while, it was certain, he would send him to his death. It made no difference. In some sense that went deeper than friendship, they were intimates; somewhere or other, although actual words might never be spoken, there was a place where they could meet and talk. . . . His mind *contained* Winston's mind. . . . The peculiar reverence for O'Brien, which nothing seemed able to destroy, flooded Winston's heart again . . . never did O'Brien fail to understand what was said to him (20, pp. 255-256, 259, 276).

Deep as it may be however, it appears that understanding alone is not enough. It must be combined with a genuine respect for the client. The beginning of the development of self-esteem in the client is the experience of being esteemed by the therapist. This is apparently the basis of the effectiveness of the attitude of deep respect for the client, of recognition of him as a person of worth, of "unconditional positive regard" (24, p. 34). Perhaps the term "prizing" which Rogers uses expresses this succinctly. "The attitude of the therapist toward him (the client) is gradually internalized so that he can take the same attitude toward himself. He comes to prize himself, to feel that he is of value" (23, p. 204). Maslow, after describing a number of examples of therapy, notes this element in all of them. "The therapist in all cases cited was interested in the patient, concerned about him, was trying to help him, thereby proving to the patient that he had worth in the eyes of at least one person. . . . The behavior of the therapist produces in the patient the unconscious realization of being liked, protected, and respected" (18, p. 313). A number of research

studies provide evidence of the development of a more positive self-concept in client-centered therapy (26).

Therapy, then, frees the individual to make changes in his evaluation of himself and of his environment, and in his behavior. The nature or direction of the change is left to the client. He is an independent individual, responsible for his own choices and behavior.

The systematic approach described above emphasizes the common elements in human behavior, both normal and disturbed, rather than the differences among individuals. "There are many things that are *not unique* to each individual, but common to all men" (29). These common elements are felt to be more significant as a basis of understanding, and as the source of principles of human relations and psychotherapy, than the differences among individuals. The differences are not ignored, but they must be understood in the light of the commonalities. The differences represent individual efforts to achieve the goal of all behavior—the preservation and enhancement of the self—and can only be understood in relation to this common basic need or motivation.

There is a striking similarity between this concept of a basic common element in personality development and disturbances and the recent formulations of Selye (28) in physiology. Selye was impressed with the common elements in illness, the "syndrome of just being sick." In the early stages, all diseases look alike, with certain common symptoms. Selye points out that "many, if not all diseases have certain things in common, have certain non-specific features. Most of the disturbances are apparently common to many, if not perhaps even to all, diseases" (28, pp. 12, 15). These responses are the reactions of the organism to stress, and are called by Selye the General Adaptation Syndrome. Even the specific reactions to different infections are local reactions to stress. The General Adaptation Syndrome is the effort of the body "to maintain the constancy of [the] internal milieu" (28, p. 11), and is similar to Cannon's concept of homeostasis. "In

most instances disease is due neither to the germ as such, nor to an adaptive reaction as such, but to the inadequacy of our reactions against the germ" (28, p. 204). "Some diseases have specific causes, the direct actions of certain particular disease-producing agents, such as microbes, poisons, or physical injuries. Many more diseases are not caused by any one thing in particular; they result from the body's own response to some unusual situation" (28, p. 128).

The failure or breakdown of the General Adaptation Syndrome leads to diseases of adaptation. With the development of weapons with which to combat the specific disease producers, we are more and more subject to the diseases of adaptation. These include psychosomatic, nervous, and mental diseases.

Thus, there are common elements in the expression of all disease, physical and emotional. There is a common element in the causation of all disorders, physical and emotional—the element of stress. The emotionally disturbed share the physiological evidences of stress, and also, as has been suggested, their psychological factors may be considered as reactions to stress—the stress of psychological threat.

The General Adaptation Syndrome is the expression of the drive of the organism toward health, toward the preservation and enhancement of the physiological organism. All behavior, both external and internal, may thus be seen as the effort of the organism to maintain and enhance its physiological and psychological integrity. The frustration of and threat to this drive constitute stress, to which the organism responds with general reactions, as well as with specific physical and/or psychological reactions. The findings of physiological and chemical differences between mental patients and normals no doubt reflect the stress reaction in mental patients, and thus are the result of the disturbance rather than its causes. The recent discovery (3, 40) of a differential reaction of the blood of mental patients to a chemical (N, N-dimethyl-phenylene diamine) may be an indication of the stress reaction.

This is suggested by the fact that patients with other diseases, including cancer and disorders of the liver, as well as pregnant women, give the same reaction. Research (7) has shown that mental patients are under a constant, sustained stress, and that some of the chemical reactions of mental patients can be produced in normal individuals by subjecting them to stress. The fact that chronic schizophrenics fail to show the reaction may indicate that stress is no longer present.

The effectiveness of shock treatment in mental illness may be related, Selye suggests, to its stimulation of the stress reaction where it has been defective, thus temporarily mobilizing defenses. It is thus a nonspecific remedy.

A recent study (7) reports on the effects of psychological stress in normal subjects. The stress situation was frustration of success, with threat to the self-regard of the subjects. Subjects reacted differently to the stress. Some subjects were able to master the stress situation, while others were not. Different personality characteristics seemed to be related to acute reaction to stress and the ability to master stress. Though the results are confusing, the authors, on the basis of this study and previous studies of mental patients, suggest that "psychotic patients are under constant stress" (7, p. 293), and are alike in their failure to master stress. "The particular illness is named by the type of reaction" (7, p. 294). Thus we have another source of converging agreement with the point of view presented in this book.

THE CONDITIONS OF PSYCHOTHERAPY

If there is a common factor in personality disturbance, then it would follow that a common, or single, approach to therapy would be effective. If stress, resulting from psychological threat or frustration, is the common element, then it would appear that therapy should involve the removal of threat and/or the development of the ability and methods of handling the threat or frustration.

It was suggested above that the (temporary) removal of threat

in the psychotherapeutic situation facilitates the development of the client's ability to handle threat and frustration. Other factors facilitating this, or, as it is often phrased, releasing the positive growth forces within the individual, are understanding, acceptance, and showing respect for the client—"prizing" him or treating him as worthy of esteem. Maslow's statement of the conditions fostering self-actualization, or health, is similar to a definition of client-centered therapy: "A good environment (in theory) is one that offers all necessary raw materials and then gets out of the way and stands aside to let the organism itself utter its wishes and demands and make its choices (always remembering that it often chooses delay, renunciation in favor of others, etc., and that *other* people also have demands and wishes" (18, p. 349).

Rogers has recently presented a concise statement of the necessary and sufficient conditions of therapeutic personality change.

For constructive personality change to occur, it is necessary that these conditions exist and continue over a period of time:

1. Two persons are in psychological contact.
2. The first, whom we shall term the client, is in a state of incongruence, being vulnerable or anxious.
3. The second person, whom we shall term the therapist, is congruent or integrated in the relationship.
4. The therapist experiences unconditional positive regard for the client.
5. The therapist experiences an empathic understanding of the client's internal frame of reference and endeavors to communicate this experience to the client.
6. The communication to the client of the therapist's empathic understanding and unconditional positive regard is to a minimal degree achieved.

No other conditions are necessary. If these six conditions exist, and continue over a period of time, this is sufficient. The process of constructive personality change will follow (25).

These conditions incorporate the ideas expressed earlier in this chapter. Some of the reasons how, or why, these conditions are effective have been developed above.

Rogers points out that these conditions do not include any limi-

tations with regard to the type of client, or the severity of the personality disturbance. That is, there is no essential difference in the treatment of a relatively normal individual with minor problems, and the severely disturbed psychotic patient. Nor do the conditions require any highly specialized psychological, psychiatric, medical, or religious knowledge or information. Nor is it required that the therapist have an accurate diagnosis of the client. (See Chapter 10.)

While Rogers states that these conditions seem to be necessary and sufficient conditions for psychotherapy, he also indicates that they are in the nature of hypotheses. They have not been proved, but are capable of being tested. To be necessary and sufficient conditions, it must be shown (1) that wherever the conditions are present, therapeutic change occurs, and (2) wherever they are absent, therapeutic change does not occur. Does, then, the fact that other than client-centered types of psychotherapy succeed invalidate the necessity of these conditions? Not, it should be obvious, if other types of psychotherapy include these conditions. A good case could be made for the statement that all successful approaches to psychotherapy, regardless of what else they include, contain these basic conditions. (See Chapter 8.) But if these conditions are absent, can it be shown that therapy does not occur? What about the results of the highly authoritative or directive types of psychotherapy? In some cases it might be maintained that the conditions are actually present. But in apparent, or claimed, successes where they are not present, a factor to consider is the definition of success. What constitutes constructive or psychotherapeutic personality change? This question involves the goals of psychotherapy, which have been discussed in Chapter 4. It would perhaps be generally agreed that symptom elimination or improvement is not an adequate criterion. Temporary or brief change would not be sufficient. Nor, in the view of many (if not most) therapists would a situation where the client continued to be dependent on the therapist; lacked confidence, self-respect, or self-esteem; or was unable to

accept responsibility for himself. Some of us feel that apparent successes of such methods as suggestion, persuasion, advice-giving, hypnotism, etc. are successful only in a limited sense, or for brief intervals of time. (See Chapter 13.)

The simplicity and naturalness of these conditions have implications for the question of who is to do psychotherapy, as Rogers suggests. Maslow notes that "psychotherapy is not at its base a unique relationship, for some of its fundamental qualities are found in all 'good' human relationships." He continues, "Certainly we need not be afraid as professionals of putting into the hands of amateurs these important therapeutic tools: love for other human beings and respect for other human beings. While they are powerful tools they are not dangerous ones. We may expect that ordinarily we cannot hurt anybody by loving and respecting him (except occasional neurotic individuals, who are, in any case, badly off already). It is fair to expect that love and respect are forces almost always for good and not for harm" (18, pp. 314, 320-321). It is difficult to understand Maslow's exception of certain neurotics, if love and respect are conditions of psychotherapy. The implications of this for social relationships, or the development of a therapeutic society, are obvious. Rogers states that "Where a client-centered approach is consistently utilized, it is our judgment that very rarely would the client leave the experience more disturbed than when he came in" (22, p. 230).

The six conditions enumerated by Rogers, therefore, may be accepted as hypotheses, based on a systematic approach to human behavior and psychotherapy, for the counselor interested in developing a therapeutic relationship. They are amazingly simple in appearance, though perhaps not so simple in application. In the next chapter we shall consider their implementation in a therapeutic relationship.

REFERENCES

1. Arbuckle, D. S. The general counselor: must be eclectic? *J. consult. Psychol.*, 1951, 15:76-78.

A Systematic View of Counseling and Psychotherapy 157

2. Blake, R. R., & Ramsey, G. V. (Eds.) *Perception: an approach to personality*. New York: Ronald, 1951.
3. Brain Research Foundation. *Blood tests in mental illness: papers and discussions presented at the Annual Scientific Conference of the Brain Research Foundation*, January 12, 1957. Chicago: Author, 1957.
4. Brain, W. R. The thirtieth Maudsley lecture: perception and imperception. *J. ment. Sci.*, 1956, 102:221-232.
5. Conant, J. B. *Modern science and modern man*. New York: Columbia University Press, 1952.
6. Dobzhansky, T. *The biological basis of human freedom*. New York: Columbia University Press, 1956.
7. Funkenstein, D. H., King, S. H., & Drolette, Margaret. *Mastery of stress*. Cambridge: Harvard University Press, 1957.
8. Goldstein, K. *The organism*. New York: American Book, 1939.
9. Hallowell, A. J. *Culture and experience*. Philadelphia: University of Pennsylvania Press, 1955.
10. Helfand, I. Role taking in schizophrenia. *J. consult. Psychol.*, 1956, 20:37-41.
11. Henle, Mary. Some problems of eclecticism. *Psychol. Rev.*, 1957, 64:296-305.
12. Hilgard, E. A. Human motives and the concept of the self. *Amer. Psychologist*, 1949, 4:374-382.
13. Janet, P. *Les Névroses*. Paris: Ernest Flammarion, 1915.
14. Jessor, R. Phenomenological personality theories and the data language of psychology. *Psychol. Rev.*, 1956, 63:173-180.
15. Krech, D., & Crutchfield, R. S. *Theory and problems of social psychology*. New York: McGraw-Hill, 1948.
16. Lecky, P. *Self-consistency, a theory of personality*. New York: Island Press, 1945.
17. MacLeod, R. B. The phenomenological approach to social psychology. *Psychol. Rev.*, 1947, 54:193-210.
18. Maslow, A. H. *Motivation and personality*. New York: Harper, 1954.
19. Newcomb, T. M. *Social psychology*. New York: Dryden, 1950.
20. Orwell, G. *Nineteen eighty-four*. New York: Harcourt, Brace, 1949.
21. Patterson, C. H. Is psychotherapy dependent upon diagnosis? *Amer. Psychologist*, 1948, 3:155-159.
22. Rogers, C. R. *Client-centered therapy*. Boston: Houghton Mifflin, 1951.
23. Rogers, C. R. Client-centered therapy: a current view. In Frieda Fromm-Reichmann & J. L. Moreno (Eds.), *Progress in psychotherapy: 1956*. New York: Grune & Stratton, 1956.
24. Rogers, C. R. *A theory of therapy, personality and interpersonal rela-*

- tionships as developed in the client-centered framework.* Chicago, 1956. (Mimeographed.)
25. Rogers, C. R. The necessary and sufficient conditions of therapeutic personality change. *J. consult. Psychol.*, 1957, 21:95-103.
 26. Rogers, C. R., & Dymond, Rosalind F. (Eds.) *Psychotherapy and personality change.* Chicago: University of Chicago Press, 1954.
 27. Ruesch, J., & Kees, W. *Nonverbal communication.* Berkeley: University of California Press, 1956.
 28. Selye, H. *The stress of life.* New York: McGraw-Hill, 1956.
 29. Skaggs, E. B. Ten basic postulates of personalistic psychology. *Psychol. Rev.*, 1947, 54:255-262.
 30. Smith, M. B. The phenomenological approach in personality theory: some critical remarks. *J. abnorm. soc. Psychol.*, 1950, 45:516-522.
 31. Snygg, D. The need for a phenomenological system of psychology. *Psychol. Rev.*, 1941, 48:404-444.
 32. Snygg, D., & Combs, A. W. *Individual behavior: a new frame of reference for psychology.* New York: Harper, 1949.
 33. Snygg, D., & Combs, A. W. The phenomenological approach and the problem of "unconscious" behavior: a reply to Dr. Smith. *J. abnorm. soc. Psychol.*, 1950, 45:523-528.
 34. Stanton, A. H. Theoretical contribution to the concept of milieu therapy. In *Theory and treatment of the psychoses: some newer aspects.* St. Louis: Washington University Press, 1956.
 35. Symonds, P. M. *Dynamics of psychotherapy: Vol. 1: Principles.* New York: Grune & Stratton, 1956.
 36. Thorne, F. C. *Principles of personality counseling.* Brandon, Vermont: Journal of Clinical Psychology, 1950.
 37. White, R. W. *The abnormal personality.* (2nd ed.) New York: Ronald, 1956.
 38. Wiener, N. *The human use of human beings.* (2nd ed. rev.) Garden City, N.Y.: Doubleday Anchor Books, 1954.
 39. Williamson, E. G. *Counseling adolescents.* New York: McGraw-Hill, 1950.
 40. Syringes for schizophrenics? *Time*, May 27, 1957, 59 (21):66-71.

CHAPTER 8

Implementing the Point of View

The preceding chapters have laid the foundations for a discussion of the counseling process. Problems of ethics and values in counseling, the significance of cultural factors for the counselor and client, and the outlines of a systematic approach to counseling have been discussed. We are now ready to consider the practice of counseling. It has been indicated that understanding is the basis of the counseling relationship. But how does the counselor achieve understanding of the client, and what does he do with his understanding?

This chapter will consider the counselor's approach to the first interview with a client, and the fundamental techniques of a counseling relationship. But first, a word of caution to the beginning counselor.

COUNSELOR EXPECTATIONS

The neophyte counselor is prone to enter counseling and psychotherapy with unrealistic expectations of what will be achieved in the process. He has ideas and dreams of facilitating sudden, far-reaching, even miraculous changes in his clients. He may anticipate the glowing satisfactions resulting from grateful clients attributing new lives to the counselor.

The counseling student should be disillusioned about this before he starts. If he isn't, he will suffer considerable anxiety during the early stages of his counseling practice, anxiety which may interfere with the effectiveness of his counseling. Counseling, or psychotherapy, is no profession for anyone who is dependent upon spectacular results for the satisfaction of a need for accomplishment. It is no place for the impatient person, eager to see results immediately, or dependent upon rapid, easily observable progress in his clients for his own professional satisfaction and self-esteem.

It must be recognized that psychotherapy offers few such rewards. There are few cases so dramatic as that of Marjorie Winkler (48, pp. 312-322). The problems of evaluating the outcomes of psychotherapy are unsolved, but such information as we have is sobering (13, 14, 21, 37). Few therapists claim much more than 50 percent success in their work. The psychoanalysts, who select their clients carefully, report success in only about two out of three of their cases (e.g., 21). Their standards, while high (though admittedly subjective), do not involve complete cures. Indeed, there are few who feel that complete cures are possible in psychotherapy—or in any method of treating mental and emotional disturbances.

It is perhaps only reasonable not to expect too much from psychotherapy. When a client enters therapy he has behind him years or decades of living and experience, often of unhappy, disturbed living. Attitudes and habits built up and practiced during this long period of time do not yield easily to change, as anyone knows from his own experience. Psychotherapy, even an intensive psychoanalysis of several years with daily sessions, constitutes but a small part of the life experience of any individual. There are few sudden and deep changes in human behavior; few Sauls have been transformed into Pauls. Few sows' ears become silk purses. Freud was well aware of the difficulties and limitations of psychotherapy and cautioned against unrealistic expectations. As Wyatt points out, "It does not make biological sense that an organism molded into a

certain pattern under innumerable influences over many years, should be changed profoundly through an influence within a few months. A therapist who insists on the rebirth of his patients may have missed his calling" (57).

However, realization of the slowness of and obstacles to personality change should not lead to an attitude of pessimism. Even though difficult to demonstrate or to document quantitatively, perhaps no one, with possibly a few exceptions such as Eysenck (13), would deny the possibility of personality change, sometimes radical, through psychotherapy. It is also true that in some cases such change can be relatively rapid. A change in perspective, or in perception, on the part of the client may lead to rather sudden and marked changes in behavior and personality. There is some evidence that the self-concept may change rapidly and radically, and behavior may follow the change.

The point to be made is that the counselor must be patient, not easily discouraged, and satisfied with moderate or even minimal results with many if not most of his clients. Above all, he must not blame or condemn himself for all his failures, or for being unable to work miracles. Psychotherapy requires of its practitioners that they be satisfied with small rewards, content to have been of some help to some clients.

If the counselor does not expect rapid and extensive changes in his clients, he is relieved of one source of anxiety about his effectiveness. He does not question his competence when such changes do not occur. Moreover, if he respects the client and has confidence in the client's ability to take responsibility for and to work out his own problems, he is relieved of another threat to his feeling of competence. He does not worry about whether he can answer the client's questions, since he does not feel he should be able to do so. He does not become concerned that he cannot keep a few steps ahead of the client—he does not regard this as necessary. He does not feel inadequate if he cannot see an answer to the client's problems before the client does—this is not a requirement of success in

the counseling relationship. The counselor must be secure, or in Rogers' term "congruent" in the counseling relationship (34, 35). This does not necessarily mean that he is a paragon of adjustment. But, as Maslow puts it, "He should be emotionally secure and should have a healthy self-esteem" (26, p. 320). As indicated in Chapter 5, one cannot respect others unless one respects oneself. And if the counselor insists on expecting or demanding too much of himself he cannot but feel inadequate, unless he develops a false sense of omnipotence and omniscience. The counselor who does not demand the impossible of himself is not threatened by the unrealistic expectations or requests of clients that he provide them with answers and solutions to all their problems. He is able and willing to admit that he cannot do so, and being able and willing to do this, he is not anxious about the client bringing up such requests.

It is desirable to minimize anxiety in the therapist, since anxiety interferes with the ease of communication between the client and therapist (3). Also, Brody suggests that "The doctor's anxiety may be taken by the patient as confirmation of his own fear of being threatening and tends to decrease the patient's self-esteem if not to force the patient to assume that the doctor has no real grasp of the problem" (7, p. 47).

THE INITIAL CONTACT—RAPPORT

Probably no student of counseling approaches his first client without some anxiety. Perhaps it is not possible to eliminate completely this feeling of apprehension. The student cannot be prepared completely for the client. One can never predict just what a client will be like or just what he will do or say. The previous chapter pointed out how impractical it is to provide the student with a complete repertoire of responses to be used under specific conditions, as appears to be required by an eclectic approach.

The student's apprehension can be reduced somewhat by certain experiences of a vicarious nature. These will include reading and

listening to recorded cases and excerpts from cases. Role-playing is another useful technique. Nevertheless, every client is different from every other client, and every counselor-client interaction is different. Every interview is an entirely new experience in interpersonal relationships. Moreover, the counseling interaction is and must be spontaneous. Specific preparation, the memorizing of responses to be used in certain situations, destroys this spontaneity. It remains true that only experience can gradually diminish the anxiety with which the counselor approaches his first interview with a client. It is only with experience that the counselor can look forward to the appointment with a new client with anticipation rather than apprehension, with confidence rather than anxiety.

The student, if he has read at all in the literature on counseling, is probably anxious about the problem of rapport. Rapport is a term glibly referred to by students who desire to appear informed about counseling. Textbooks emphasize the necessity of rapport and present it as something to be achieved by the use of specific techniques. A recent text on counseling provides a good example of this concept of rapport:

A *good* counselor *always* comes out of the office to meet his client. He often greets him with a friendly, courteous hand clasp, and he *always* calls him by name as he escorts him into the office. . . . After the entrance, rapport can *best* be established by a brief period in which the student is put at ease. Perhaps the *best* technique is to open the conversation on some topic or hobby of special interest to the person interviewed. Such questions as "Who is going to win the game this week?" or "How are you doing this semester?" sometimes break down shyness in a student. Another device suggested by Symonds is for the interviewer to associate himself in some way with the client's past experience. "A reference to common friends often makes an excellent bridge with which to span the gap. The discovery that both have lived in the same village, visited the same city, taken the same trip, enjoyed the same show, or attended the same school will serve as an effective means of gaining rapport." This device is no doubt familiar to many counselors, and it is very effective. A technique often used by social workers is also appropriate for counselors. It consists of having a conversation piece on one's desk: A ship model, a child's photo, an interesting gadget—something of interest which may attract the client's attention and

serve to break the silence of the initial contacts (45, pp. 68-69, italics added).

This approach goes so far as to be concerned about whether to call the client by his first or last name (46). Tyler, while seeming to accept this general approach, cautions about its backfiring.

Just what should be done varies from one interview to another. Experienced interviewers usually recommend to novices that they carry on some sort of general conversation during the early part of the interview until the counselee begins to feel at ease in this new situation. The skill involved here is that of picking up clues to topics of conversation likely to interest the person. If the counselor has seen him at a game, an art exhibit, or a concert, to mention that fact may be a good beginning. Something the person is carrying with him—a book, a package of phonograph records, or a tennis racket—may be a good point from which to start. Mutual friends or a part of the country they both know may furnish material for conversation. One must be alert in using any of these cues, however, to the possibility that it is a disagreeable rather than a pleasant topic (53, p. 28).

She continues: "But even this is no invariable rule. Counseling is not conversation and it is not essential that it be maintained or even begun on a pleasant level" (53, p. 29). Counseling is not a social relationship.

This approach to the initial interview is apparently based on the assumption "that most students are reluctant, at least at first, to discuss their background and problems" (54, pp. 138-139). It is possible that many clients find it difficult to begin discussing their problems, though it is doubtful that many are actually reluctant to do so. One must assume that their purpose in coming to the counselor was to discuss their problems—not the weather, the past or coming football game, or other events. They need help in talking about their problems, not in social conversation. Tyler's comment that counseling is not conversation is pertinent. To make it so interferes with the counseling relationship in two ways: it makes more difficult the development of a professional rather than a social relationship, and it wastes the client's time.

Davidian (9) distinguishes two concepts of rapport. The first

she calls the "glad hand method" which we have just described. She identifies this with our cultural approach to new acquaintances in a social situation. To use it with a client introduces irrelevant material which might augment his problem. "Of greatest interest to him at this moment is his problem, interested though he may be in dramatics, athletics, or various hobbies" (9). The concept of rapport represented by this approach is, as Sanderson points out, "an artifact when compared with a genuine interpersonal relationship . . . the establishment of a rapport, in this sense of the word, is undesirable, for it tends to place the main burden of the relationship on the counselor and appears to relieve the client of the responsibility of making the interview a valuable experience" (42, p. 36). The second approach Davidian calls the "get wet all over" technique. The counselor recognizes the problem as vital; he realizes that the client is there on business, not to pay a social call, and he gets right down to the business. The approach is simple and direct: "What's on your mind?" or a variation of this question. The client may not be able to verbalize his problem immediately or easily, or know just where to begin. It is here that the counselor becomes uneasy, and it is actually his uneasiness which leads him to irrelevant "small talk." As Davidian puts it, "Might it not be that the over-conscious feeling on the part of the counselor that there is a need for creation of rapport causes many of our difficulties in attaining it?" (9).

In contrast with the concern of counselors about creating or developing rapport through irrelevant social conversation is the direct approach of most psychotherapists and psychiatrists. Coleman (8), for example, discussing the initiating of psychotherapy, states: "It is important to introduce patients to treatment immediately." A study (12) of therapeutic interviews found that the shift from conventional pleasantries to the work of analysis hindered the therapeutic process. The investigators concluded that "the absence of such pleasantries, with an immediate approach to the work of the interview, in itself seems to indicate a more con-

junctive integration of therapist and patient." Fromm-Reichmann makes a significant observation:

I strongly advise against any attempt on the part of the psychiatrist to make things seemingly easier for the patient by pretending that the professional doctor-patient relationship is a social one. Deep down in his mind, no patient wants a nonprofessional relationship with his therapist, regardless of the fact that he may express himself to the contrary. . . . Moreover, the psychiatrist who enters into a social relationship with his patient may easily become sufficiently involved himself in the nonprofessional aspects of this relationship to be rendered incapable of keeping control over the professional aspects of the doctor-patient relationship (18, p. 46).

Rapport is thus not something to be achieved by techniques as social devices. "It is not superimposed, it is not artificial, it is not turned on or off at the counselor's door" (9). It is something that develops and exists where the counselor is genuinely interested in and concerned about the client and his problems. Sanderson states that "establishing a rapport and winning confidence become stumbling blocks when they are treated as ends in themselves. . . . Winning confidence as a technique has no place in a genuinely straightforward relationship" (42, pp. 108, 110). Where the counselor is interested and concerned, and the client is aware of this, rapport exists. No special techniques are necessary or desirable.

THE PROBLEM OF TECHNIQUES

The foregoing indicates that rapport is not a matter of techniques. Earlier chapters have stressed that the essence of counseling and psychotherapy is a philosophy or attitude toward people. The two principles of respect for the client as a person of worth, and an understanding of him as a unique person have appeared as the basis of therapeutic counseling. What then is the place of techniques in counseling and psychotherapy? What does one say when the student asks, "Just what do I do, what should I say?"

Counseling is a philosophy, or a set of attitudes toward the client. But it is nevertheless true that these attitudes must be ex-

pressed by the counselor. The counselor must do or say something. What he does or says may be considered as techniques. Without taking the emphasis from attitudes, one can maintain that certain techniques are more consistent with certain attitudes than are others.

It is true that strong attitudes may, as suggested in Chapter 4, manifest themselves in counseling without any effort or intention on the part of the counselor. It is also true that attitudes of interest and respect may be clothed in techniques which appear to be inconsistent with the attitudes. (This phenomenon will be considered in a later chapter.) It is nevertheless helpful to the beginning counselor to consider how he might implement his attitudes toward the client. While it is essential that the counselor be himself, it is also true that he must be his counseling or therapeutic self, rather than his social or teaching self. The techniques of implementing the therapeutic attitudes, the therapeutic self, are somewhat different from the techniques of everyday social intercourse.

The aim of the counselor is to express his interest in the client, to show that he accepts the client as someone worthy of respect and esteem, to express his "unconditional positive regard" (34, pp. 34, 44-45; 35), to understand the client, and to convey this understanding to the client. What actions on the part of the counselor will achieve these objectives? How can he achieve this and at the same time allow the client to be responsible for himself, for his communications and his behavior, from the beginning of the first interview?

The problem of teaching psychotherapy has been considered a difficult one. Bateson writes that "The psychiatrists are short of words to describe the implementation of their task. Very little has been done to specify the tricks and recipes of therapy. Indeed, it is a common complaint of young psychiatric residents and others who apprentice themselves to the profession that their teachers cannot tell them what to do" (40, p. 235). While there certainly

has been no dearth of attempts to describe the therapeutic process, such complaints are probably true. Bateson quotes a Freudian psychotherapist as saying, "The more experience I have in psychiatry, the more convinced I become that it is impossible to verbalize what I do" (40, p. 246). It is true that many good therapists function intuitively. It is also true that we do not yet know, at least experimentally, what constitutes good therapy.

But it is also possible that the complexity of psychotherapy has been overestimated, or that it has been made more complex than is necessary. Without implying that it is easy to become a good therapist, it is suggested here that psychotherapy is much less complex than is commonly supposed. The fundamental principles and techniques of psychotherapy appear to be few and relatively simple, though it is by no means easy to become proficient in their use.

LISTENING

The basic, most universal, most important technique in counseling and psychotherapy is listening. Listening to what another has to say is a basic manifestation of interest and respect. Even in ordinary social intercourse its value is recognized. Zilboorg says: "This is always true—not only in psychiatry: the less you talk the better" (58, p. 108).

Fromm-Reichmann writes as follows:

What, then, are the basic requirements as to the personality and professional abilities of a psychiatrist? If I were asked to answer this question in one sentence, I would reply, "The psychotherapist must be able to listen." This does not appear to be a startling statement, but it is intended to be just that. To be able to listen and to gather information from another person in this other person's own right, without reacting along the lines of one's own problems or experiences, of which one may be reminded, perhaps in a disturbing way, is an act of interpersonal exchange which few people are able to practice without special training. To be in command of this act is by no means tantamount to actually being a good psychiatrist, but it is a prerequisite of all intensive psychotherapy (18, p. 7).

To listen is perhaps the most difficult thing a student counselor

has to learn. Not only must he avoid jumping in to direct the client's remarks, breaking in to ask questions, or attempting to demonstrate his competence or knowledge; he must be able to listen without preoccupation with his own attitudes, feelings, or needs. Fromm-Reichmann quotes Freud as saying that "the psychoanalyst's job is to help the patient, not to demonstrate how clever the doctor is" (18, p. 19).

But what if the client doesn't talk, even when given every opportunity? How long should the counselor remain silent? While much counseling can be conducted in silence, it is doubtful if much can be accomplished if the client never talks from the beginning of the first interview. It is not necessary that the counselor remain absolutely silent until the client starts talking. Client-centered or nondirective counseling does not necessarily imply, as is often assumed, inactivity of the counselor. The counselor may be active. He may take the initiative in some cases. But he does this without taking the responsibility for the interview. While not being responsible for the direction of the interview or its outcome, the counselor is responsible for providing, to the best of his ability, an atmosphere in which the client can express himself. The counselor can attempt to express his interest in the client, his sincere desire to try to help him. He attempts to avoid the suggestion of any threat to the client. Prolonged silence may be threatening to the client. If the client is to express himself at all, it will be in a nonthreatening atmosphere. But the techniques of "small talk" and the techniques of achieving rapport discussed above do not serve to remove the sense of threat. They may only accentuate it by evidencing discomfort on the part of the counselor. Nor do they make it any easier for the client to talk about himself. They only postpone this, and may make it more difficult. Urging or encouraging the client to talk usually doesn't help either. Paradoxically, assuring him that he doesn't have to talk if he feels unable to do so is more apt to help him to talk.

Some clients are completely unable to express themselves even

in the most nonthreatening atmosphere. Sometimes the interview may be terminated, and the client can be invited to return later. Even if the counselor has been uncomfortable, or is pessimistic about the future possibility of the client being able to talk, he should offer another appointment. Counseling, or the attempt at counseling, should be continued as long as the client desires to struggle with it.

It is unfortunately true that there are people with problems who cannot verbalize sufficiently to enter into a counseling relationship. As indicated in Chapter 5, there is, at least at present, little that can be done to help these people. In the vocational counseling of mute clients, something may be accomplished in some cases by working along the lines suggested by the writer in a previous publication (29, pp. 209-210). There is also some promise in the approach to severely disturbed patients referred to in the discussion of nonverbal communication later in this chapter.

UNDERSTANDING

Listening not only shows acceptance and respect; it is the basis for understanding. Listening alone is not sufficient, however, even the interested, attentive listening of the counselor who is free from the interference of his own needs. A particular kind of listening may, however, result in understanding. Understanding, it will be recalled, is one of the conditions of therapeutic personality change stated by Rogers (34, 35).

Understanding is more than knowledge. It is something more than all the details of facts that can be acquired about a client. Actually, such information is not necessary for a genuine understanding. Understanding is not evaluation—in fact, an evaluative attitude interferes with real understanding. Understanding is not classification, labeling, pigeon-holing. As Zilboorg writes, "It matters very little whether or not you understand what you call the Oedipus complex, but it matters a great deal whether you understand your patient" (58, p. 108). Reik says that "Only when

he (the therapist) is ready to drop all speculation while he analyzes will he be able to catch the emotional undertones in what his patient says" (32, p. 116). Evaluative activity interferes with understanding the client as a unique individual. All these things have been confused with understanding. They are knowledge about an individual, but not knowledge of him.

Understanding as a basis of psychotherapy is a "feeling with," an *Einfühlung*. While the Bible refers to love that passes all understanding, a true deep understanding is akin to love, love as Rogers (33, p. 159) expresses it "in its deepest and most general meaning—that of being deeply understood and deeply accepted." This understanding is so deep that it is responded to with a similar love. In the incident in Orwell's *Nineteen Eighty-Four* (28, p. 255) referred to in the preceding chapter, Winston, even though tortured by O'Brien, is characterized by Orwell as experiencing a deep feeling of love for O'Brien because he feels understood.

Therapeutic understanding is achieved by trying to see things from the client's point of view. It involves an internal frame of reference for viewing the client and his environment. The counselor must attempt to place himself in the client's place. In terms of the phenomenological point of view described in earlier chapters, it means entering into the perceptual field of the client.

This concept of understanding involves the process of role-taking dealt with earlier (Chapters 5 and 7). It also is related to, or a result of, empathy. While empathy is sometimes conceived of as an intuitive process, it is frequently defined as role-taking ability. Dymond, for example, defines empathy as "the ability to feel and describe the thoughts and feelings of others," or as "the imaginative transposing of oneself into the thinking, feeling and acting of another and so structuring the world as he does" (10, 11). Rogers says that "The state of empathy, or being empathic, is to perceive the internal frame of another with accuracy, and with the emotional components and meanings which pertain thereto, as if we were the other person, but without ever losing the

'as if' condition" (33, p. 38). The loss of the "as if" element results in identification.

Empathy is thus the basis of understanding. Empathy, or role-taking, is aided by a broad knowledge of human nature. The basic similarities of human beings provide the essential foundation for empathy. As Sullivan phrases it, ". . . we are all much more simply human than otherwise" (51, p. 7). This commonality in terms of basic motivation has been discussed in the preceding chapter. People do vary, however, in their expressions of common motivations, and in the content of their experiences. The greater the counselor's background of experience in human relations, both at first hand and through vicarious experience, the greater his capacity for understanding and empathizing with others. The question as to whether test and diagnostic information is of value in understanding will be discussed in a later chapter.

Understanding, or empathy, seems to be recognized as a basic element in every psychotherapeutic technique (27). Bordin writes that "Whether one assumes that the processes of therapy are solely those of understanding and acceptance of the client or one assumes that therapy involves understanding plus some form of interaction with the client, achieving the deepest possible understanding will remain as one of the prerequisites of effective counseling or psychotherapeutic processes" (6, p. 163). And Alexander says that ". . . the common sense or intuitive understanding of human nature is the basis of all rational psychotherapies" (1, p. 83).

The importance of understanding, and the client's perception of the counselor's understanding in the therapeutic relationship is indicated by Fiedler's studies (15, 16, 17). In two studies (15, 16) Fiedler used a total of 18 subjects, including experienced and inexperienced therapists with psychoanalytic, Adlerian, and client-centered orientations, and three laymen. These subjects sorted statements descriptive of client-therapist relationships, using the Q technique. Fiedler found that the experts of the different schools correlated higher with each other than with nonexperts of their

own schools. Factor analysis yielded one common factor of goodness of therapeutic relationships. The ideal relationship, described by the items with the highest ratings by the most expert therapists, clearly reflects the importance of the therapist's ability to understand and to communicate his understanding of the client:

1. The therapist is able to participate completely in the patient's communications.
2. The therapist's comments are always right in line with what the patient is trying to convey.
3. The therapist is well able to understand the patient's feelings.
4. The therapist really tries to understand the patient's feelings.
5. The therapist always follows the patient's line of thought.

In the second study (16) Fiedler also attempted to determine whether expert therapists from different schools actually achieve the common ideal more closely than nonexperts. Recorded interviews of expert and nonexpert therapists of three different schools were rated by four judges, who varied widely in training and orientation, by means of the Q technique, using the statements from the previous study. It was found that the experts correlated higher with the ideal than the nonexperts, and that the experts resembled each other more closely than they resembled nonexperts of their respective schools in the type of therapeutic relationship which they created. Statements were classified in three categories: (1) those concerned with communication and understanding of clients; (2) those concerned with maintenance of an appropriate emotional distance, and (3) those concerned with status role in regard to clients. Experts differed from nonexperts only on the first category. Statements from the other two categories did differentiate among the schools, while only two of the 25 from the first category showed any such differences. Factor analyses of the ratings of each judge (17) yielded several factors which distinguished experts from nonexperts. These factors characterized the experts as being better able to communicate with and to understand the client and to empathize.

In a different type of study, in which client-centered and psychoanalytically oriented psychologists responded to isolated client statements from published interviews, Strupp (49) found little difference between experienced and inexperienced therapists, but greater differences between client-centered and psychoanalytically oriented therapists. Client-centered therapists gave many more simple reflection responses, while those psychoanalytically oriented gave more passive acceptance and exploratory responses. The majority of the responses of both groups (94.1 percent of the client-centered and 75.6 percent of the psychoanalytically oriented) were contained in 4 of the 12 categories, that is, the reflection, exploratory, passive acceptance, and integration categories. Although the reliability of classification of responses is high, there seems to be no clear-cut distinction between some of these categories. In spite of the statistical results, there seems to be relatively little real difference between the two groups. In a study of 25 psychiatrists, 9 psychiatric social workers, and 7 psychologists, all psychoanalytically oriented, Strupp (50) found similar profiles for types of responses, with little difference between the experienced and inexperienced therapists. Experienced psychiatrists tended to use many interpretative responses. Interpretation of course presupposes understanding on the part of the interpreter. In general, in both of these studies by Strupp, experience seemed to result in greater diversification of technique. It must be remembered that the results of these studies may be affected by the nature of the method of obtaining responses, that is, by response to isolated statements. Fiedler's studies, on the other hand, dealt with actual interviews, and were not concerned with isolated responses, but with evaluation of the therapeutic relationship achieved.

COMMUNICATION OF UNDERSTANDING

It is not enough that the counselor understand his client; the client must know that he is understood. It is therefore necessary that the counselor convey his understanding to the client. Rogers

(35), it will be recalled, states as one of the conditions of psychotherapy that the communication of the therapist's understanding to the client must be minimally achieved. Elsewhere (34, 36), Rogers has stressed the necessity for the client to feel that he is "being received." In discussing (34) the conditions of psychotherapy, he omits any statement that the counselor endeavors to communicate his understanding to the client. He writes that "Such a statement has been omitted only after much consideration, for these reasons. It is not enough for the therapist to communicate, since the communication must be received . . . to be effective. It is not essential that the therapist intend such communication, since often it is by some casual remark, or involuntary facial expression, that the communication is actually achieved" (34, p. 41). Nevertheless, he agrees that successful communication whether intended or striven for by the counselor, is essential.

Client-centered techniques consist mainly of two types: (1) those which implement or manifest the counselor's attitude of interest in, respect for, and recognition of the individual client and his personal worth and integrity—the expression of esteem or unconditional positive regard; and (2) those which are designed to convey the counselor's understanding of the client to the client. The former includes listening or silence, and simple acceptance, such as "M-hmm," etc. The avoidance of certain techniques, such as reassurance, advice, suggestion, support, questioning or probing, and evaluation is also a reflection of respect for the client and the prevention of threat to the client and his self-esteem.

The methods by which the counselor communicates his understanding are the techniques which have been considered to be characteristic of client-centered therapy. Some of the techniques listed above are also ways of indicating understanding. Thus, silence may at times convey understanding. Simple acceptance, expressed by "M-hmm," "I see," "yes," etc., may be useful in expressing understanding. To some extent simple restatement of the client's statements, the reflection of content, may achieve this com-

munication. But perhaps the most appropriate and most commonly used method is the reflection and clarification of the client's feelings and attitudes. Rogers (33, p. 452), reporting studies by client-centered researchers, presents a definition of reflection as the attempt "to understand from the client's point of view and to communicate that understanding."

Studies of client-centered counseling methods indicate that there has been an increase in the use of these techniques of communication of understanding, compared to more directive techniques of counseling. Seeman (44) compared counselor responses found by Snyder (47) in his 1943 study with those of counselors about five years later. Responses classified as simple acceptance, reflection of content, and reflection or clarification of feeling increased from 62.6 to 85.0 percent. This is very similar to the results of Strupp's study (49), where 80.7 percent of the responses of client-centered therapists were classified as either acceptance or reflection. There is some impression that the techniques of client-centered counselors have increased in variety. Strupp (49) reports that experienced counselors utilized a wider variety of techniques. If this is so, it probably represents a search for more adequate or effective ways of communicating understanding to the client.

Perhaps it is worth pointing out that the counselor should not pretend to understand the client when in actuality he does not. Nor should the counselor allow the client to continue indefinitely when understanding is not present. If the counselor does not understand, or is not sure he understands, he should attempt to clarify his understanding. He may do this in a number of ways. Simply stating "I don't understand," "I don't follow you," or "I'm not sure I'm clear about what you are saying" may be appropriate. Questions such as "Do I understand you to be saying that . . . ?" or "Is this what you are saying . . . ?" may be appropriate. Or the counselor may ask the client to repeat or clarify what he has said, e.g., "Can you go over that again so I can be sure I understand what you are saying?"

It is not necessary that the counselor understand completely all that the client is saying. In fact, it is perhaps impossible for the counselor to do so. He may misunderstand the client, and his response may clearly show this to the client. But this is not necessarily damaging to therapeutic progress, at least if it doesn't happen too frequently. It may be true, though there is no research evidence for it, that difficulty in understanding, or repeated misunderstanding, of the client may prolong the therapeutic process.

Understanding and the conveying of understanding to the client depend upon communication. Barriers to communication, such as differences in cultural or social background, or language difficulties, may affect understanding. The writer has had students from other countries, whose language difficulties have been a handicap in communication between the counselor and client. Possibly this has delayed progress in counseling. But in some cases at least it seems not to have been an impediment, but perhaps even a help, since the client in his attempts to make himself understood may explore his own thinking and feelings more deeply. The fact that the counselor is sincerely trying to understand the client is often sufficient for therapeutic progress in the face of communication barriers.

Communication is thus the basis of understanding, not an end in itself. Ruesch and Bateson appear to consider communication as the goal of psychotherapy: "One can say with certainty that the therapeutically effective agents contained in psychotherapy are to be found in communication" (40, p. 79). Perhaps there is justification for this. If understanding depends on communication, then communication itself can be conceived of as the goal. Indeed, it may be that understanding and communication may be considered as synonymous, which is what Ruesch and Bateson apparently do.

The acceptance of the communicating of understanding as one of the basic goals of counselor techniques, along with the goal of accepting and prizing the client as a person of worth, has some relevance to the question of what the counselor responds to in the

client's statements. This question arises particularly where the client has expressed many attitudes or feelings of a conflicting nature. It is possible that it doesn't matter to what the counselor responds as long as the client perceives it as respect and understanding. To be sure, it is probably true that the more of the client's total statement which can be responded to, the more likely he is to feel understood. In the case of conflicting feelings or attitudes, for example, a reflection of the existence of conflict, rather than of one feeling alone or of each separately, may better convey the counselor's understanding. It may of course be possible that, where there are many elements to which the counselor could respond, a response to certain of these may be more effective in achieving therapeutic progress than a response to others. Some would feel that a diagnostic understanding might help to pick out the more significant elements. But the ultimate criterion, as proposed here, is the client's feeling of being understood, since this is assumed to be the condition of therapeutic progress. Diagnostic understanding may hinder rather than help in the achievement and communication of understanding of the client as a unique individual. To the suggestion that the application of a system or theory of personality dynamics may be useful, it can only be stated that it appears that progress can occur under such conditions. But it does not appear to matter what system or theory is used, at least as long as the client can accept it and learn to express his understandings in terms of its rubrics. It may also be pointed out that therapy progresses without the application of such a system or theory, so that it cannot be maintained that this is a necessary condition of therapeutic progress. It may of course be helpful to the counselor in understanding the client to be familiar with the findings of psychology about personality dynamics. While the theoretical position held by the writer is the phenomenological point of view, it does not appear to be necessary that the counselor be thoroughly familiar with this approach, though it may be held that, whether he is or not, he is applying it when he follows the counseling

approach outlined here. Although therapists from other schools of thought are successful in understanding their clients, it may also be suggested that they are successful in so far as they accept the internal frame of reference in working with their clients, and this is the essence of the phenomenological point of view.

NONVERBAL COMMUNICATION

Communication between the therapist and client is not limited to verbal communication. Ruesch and Kees (41) emphasize the breadth of the area of nonverbal communication. Hahn and MacLean (20, pp. 264-267) discuss the significance of nonverbal communication in counseling, which is not even mentioned by most books and texts in counseling or psychotherapy. In the chapter on values in counseling (Chapter 4) we have mentioned the nonverbal communication of the counselor's values to the client. Here we are concerned with the nonverbal communication of the client as a basis for counselor understanding.

Nonverbal communication involves both auditory and visual media. The tone of voice, speed of speech, pauses, hesitation, stammering, stuttering, stumbling, as well as ejaculations or other vocal expressions of emotion are means of communication. The area of visual nonverbal communication is broad, encompassing the whole field of expressive movement. Facial expressions, gestures, and other part or whole body movements, including posture, may convey meaning.

Barbara (4) notes that "We communicate every minute of every day with others and the outside world through 'speaking' gestures, peculiarities in speech and dress, a sense of touch while shaking hands, the mannerisms of another person's glance or looks, the condition or texture of his skin, the color of his eyes, his lips, his body build, and a multitude of similar characteristics." As Ruesch and Kees point out: ". . . people make the assumption that feelings are linked with certain expressive movements and that these movements escape voluntary control" (41, p. 36).

And "In daily social intercourse the assumption is made that emotions reflect the inner state of the organism—not only the more or less hidden thoughts of an individual, but particularly in his emotional expression" (41, p. 45). Moreover, ". . . verbal expression cannot adequately represent some of the nonverbal events experienced in the past" (41, p. 166). The symptoms of psychosomatic disorders are considered to represent or to symbolize, on a nonverbal level, psychological or emotional reactions, and thus to constitute an organ language, e.g., expressions such as "a pain in the neck," "load on the chest," "can't stomach it," "burn up," "can't swallow that."

The end of Chapter 5 mentioned methods of attempting to understand nonverbal clients. Ruesch (39), who feels that mental disturbance is intimately associated with disturbances in communication,¹ suggests that the more severe psychiatric conditions are associated with disturbances in nonverbal behavior, as well as in verbal behavior. If this is so, then it would account for the extreme difficulty of understanding and communicating with such patients. Nevertheless, "Therapy during the acute phases of psychosis has to make use of nonverbal means to appeal to the analogic feeling and imagery of the patient. . . . The unilateral understanding on the part of the therapist in the early phases of treatment is supplemented by bilateral interaction, paving the way for verbal . . . therapy. . . . It is only through nonverbal replies that a nonverbal patient can be influenced, and once such nonverbal interaction has been established, the organization of the patient's experiences gradually can be translated into words" (39).

A nonverbal approach to withdrawn schizophrenic patients has been attempted with some success (see, e.g., 7, 43). Tudor (52) also reports success with a somewhat similar approach by a psychiatric nurse in a mental hospital ward. We have been able to locate only two studies of nonverbal communication in the thera-

¹ "Psychopathology is defined in terms of disturbances in communication" (40, p. 79).

peutic interview. Krim (22), feeling that much so-called intuition or sensitivity is based on the subliminal perception of expressive movements, attempted to study expressive movements in therapy, and the perception of these by the therapist. She briefly reviews the statements of Schilder, Reich, Deutsch, Allport and Vernon (2) and Wolff (55). In a Veterans Administration Mental Hygiene Clinic, six male patients who had been treated by social workers for eight months were chosen as subjects. The experimenter observed six interviews with each subject through a oneway screen, without hearing the verbal interchange. The patients' movements were recorded descriptively, following the Allport-Vernon Classification Scale of Expressive Movements, by five-minute intervals. The therapist also kept notes, indicating the five-minute intervals. The study attempted to answer three questions: (1) Do movements and verbal material correspond? (2) Are attitudes communicated nonverbally that are not evident in the verbal content? (3) Is an awareness of movement patterns useful in treatment? Records of three of the cases were studied prior to observation, while the records of the other three were not familiar to the observer. The observer concluded that prior reading of the cases did not seem to affect observations, though this is doubtful; some of the observations presented in the article seem to show such influence. Two interviews with each patient were observed by two additional observers. "There were no major differences between observations of the experimenter and the control observers."

It was concluded that the answers to the above three questions were in the affirmative. Movement and content were judged to be consistent in most instances. "In general, the hypothesis that bodily expressive movements reveal characterological and emotional attitudes apart from verbal content was substantiated. . . . That attitudes not present in the content are communicated non-verbally seem [sic] evident. . . . In all cases observed, the social workers gained understanding of the patients' communications through

reading the movement records, although they tended to be aware that they responded to body cues in a general fashion."

However, these conclusions cannot be accepted without question. Several characteristics of the study suggest reservations regarding the conclusions. They are judgments based on subjective data and discussions with the therapists. No statistical analysis was attempted. The interviews were not mechanically recorded. The published notes for complete interviews are obviously incomplete. The subjects were not representative patients, most of them being much more active in expressive movements than the average client. Thus, the study is concerned mainly with gross and easily observable physical movements. The one subject who did not show this high activity did not support the conclusions. There is some question regarding the validity of some of the observations. It is difficult, for example, to credit the objectivity of such observations as the following: "Angry eye flashes," "eyes frowning angrily," "downcast eyes (like a punished boy)," "eyes blink angrily," "flashing eyes," "surprise," "expression of pride," "eyes very expressive," "laughed deprecatingly," "childlike, infantile dependence," "imploring hands," "coy, appealing, little boy look," and looking "thoughtful," "disgusted," "peevish," "skeptical," "amused," "bewildered," "crestfallen" or "remorseful." Possibly some of these observations are based on general body or posture cues. But they appear to be inferences and interpretations which can hardly be drawn from observation without knowledge of verbal content. The therapists were not aware of many of these finer expressions, yet apparently accepted them as valid observations, useful for further therapy. Perhaps this acceptance by therapists who knew the patients well is some evidence of validity, but it is hardly sufficient. The results of this study, however, are suggestive.

A study by Giedt (19) suggests that nonverbal cues may be misleading. Judges made ratings and predictions of sentence completions for four patients interviewed by a psychiatrist and a psy-

chologist. Judgments were made on the basis of (1) a silent film, (2) the typescript of the interview, (3) a sound recording of the interview, and (4) the complete sound film. Ratings based on the silent film were less accurate than those based on the other three conditions. The presence of visual cues resulted in greater variability in the ratings, suggesting that "the appearance of some expressive behavior . . . may tend either to aid or to mislead the clinicians." Predictions of sentence completions were poorer than chance when based on silent films, and predictions based on the complete sound film tended to be less accurate than those based on sound alone. The author suggests that "It may well have been that judges were misled by dress, appearance, gestures, or facial expressions."

It is clear that the therapist must be alert to nonverbal communications of the client. Much of what is commonly referred to as intuitive understanding may be derived from this source. The counselor may respond to feelings which are not verbally expressed. Nevertheless, caution must be exercised in using this means of understanding. While expressive movements and gestures are all meaningful, we have no dictionary of their meanings. Some, perhaps only a few, are clear, at least in the context of the situation—weeping or crying on the part of the client need not be verbalized or explained in many cases. But most are not. The experiments on the interpretation of emotional responses indicate that emotional expressions cannot be accurately identified, without knowledge of the stimulus or stimulus situation (see, e.g., 56). The comments of Manoil on a film concerned with nonverbal communication in psychotherapy are worth quoting:

While the psychotherapist could learn to pay more attention to nonverbal clues, the meaningful codification of these clues is not easily achieved. Actually, the whole area of nonverbal communication appears as an extension of the problem of judging emotions from facial expressions. Now, from what is known about the difficulties encountered in the limited field of facial expression of emotion, one wonders what is the actual practical value of the whole theory of nonverbal communication.

Expressive aspects of behavior appear as dynamic, direct, and immediate communication, consequently unaltered by their crystallization into verbal symbols. What is obtained by avoiding the use of words is, however, not necessarily nearer to the truth since cultural factors and learning, operating at the nonverbal level, would make expressive behavior also into a symbol system. And, if expressive behavior to be intelligible and communicable has to be codified, the nature of the problem would shift only from verbal codification to nonverbal codification.

The intuitive character in nonverbal communication can be recognized however, only as a supplementary relative clue to human interaction (25).

Thus, although those who use expressive movements "are, paradoxically, often unaware that they are revealing themselves. . . . all expressions of an individual, when perceived by another person, must be interpreted if they are to be understood" (41, pp. 14, 46). The dangers in an area where we know so little should be obvious.

CONCLUSION

This chapter has been concerned with techniques, but it must be stressed again that the emphasis in therapeutic counseling is upon attitudes rather than techniques. While the techniques suggested above appear to be the best and only necessary implementations of the client-centered attitude, it must be admitted, at least if we assume that respect and understanding are necessary conditions of therapeutic progress, that other techniques may be successfully used. Whether they are as appropriate in manifesting the basic attitudes, or as efficient in achieving results, we do not as yet know.

The techniques used by a therapist must be consistent with his personality. Also, the therapist's personality must be consistent with his therapeutic attitudes. All three are related. As Strupp says, "It is almost axiomatic that the therapist's personality and attitudes are the prime determiners of the character of his therapeutic operations" (49). We have already considered some aspects of this relationship in Chapter 3. The therapist must be, or be able to be, comfortably himself in the therapeutic relationship. It would appear that a successful therapist, at least in terms of the thera-

peutic goals accepted here, must be an accepting, understanding, democratic person.

When techniques are subordinated to attitudes, they in effect cease to be techniques in a strict sense of the word. A technique is useful, then, only when it ceases to be a technique; "it is no longer a technique in operation, but the implementation of an absorbing personal purpose" (33, p. 112), i.e., to understand the client.

Although some have felt that the therapeutic relationship is different from other good relationships, others, including many client-centered therapists, have felt that "a good therapeutic relationship is very much like any good interpersonal relationship" (15). There is some evidence in support of this point of view. Fiedler (15) found that lay raters described the ideal therapeutic relationship in a manner similar to the way therapists described it. A study of psychiatric students at the Menninger Clinic (23, 24) found that psychiatrists in training who were rated as better therapists were also rated better in their relationships with fellow students, supervisors, ward personnel, and the research staff. And Parloff (30) found that of two therapists, the one rated higher for general social relationships also was rated higher for goodness of therapeutic relationships with members of therapy groups treated by both therapists. The materials in Chapter 6 also suggest common elements in all human relationships. However, Phillips and Agnew (31), using a different method, found that, of the five types of responses listed in a multiple choice test, high school and college students chose the understanding responses least often, while experienced therapists, as well as counseling students, chose the understanding responses most frequently.

These results may not be contradictory. For while good therapeutic relationships may be related to good social relationships, actual or specific techniques no doubt vary. That is why it is necessary to give attention to techniques in the training of therapists. We cannot depend on their repertoire of social skills in psychotherapy. Nevertheless, therapy cannot be the playing of a conscious

role by the therapist. If the role which the therapist tries to play is at variance with his basic personality and attitudes, the latter will come through in the therapeutic relationship. The therapist, as suggested earlier, must be himself. As long as he is genuinely interested in the client and earnestly attempting to understand him, a conflict between doing what is natural and what it is felt should be done as a technique should probably be resolved in favor of the former.

Nor should the therapist feel that he must be rigidly the same in his therapy with different clients. Our relationships vary somewhat with each person with whom we come into contact. While basic attitudes remain constant, specific techniques may vary with different clients. The therapist's personality is different, at different times and with different people. We are all more outgoing and spontaneous at some times than at others, and it is not necessary to inhibit this tendency in the therapeutic relationship. We may be more expansive with a "manic" client, more serious with a depressed client, and we may vary with the client's mood. The essential consideration is that the variation be natural, not forced or "reasoned" in an attempt to conform to a stereotype of what we should be like.

This chapter has tried to show how the basic client-centered attitudes may be implemented through techniques in the therapeutic interview. We have not been concerned with the explication and illustration of the use of these techniques—this has been adequately treated by others (e.g., 18, 20, 33, 53). While it might seem that the essentials of psychotherapy must be more complex, nevertheless these appear to be the only necessary techniques. Rogers (35), after working on the problem of the necessary and sufficient conditions of psychotherapy, admits to his own surprise at the simplicity of what emerged.

REFERENCES

1. Alexander, F. Discussion of aims and limitations of psychotherapy, by Paul H. Hoch. In Frieda Fromm-Reichmann & J. L. Moreno,

- Progress in Psychotherapy*: 1956. New York: Grune & Stratton, 1956.
2. Allport, G. W., & Vernon, P. E. *Studies in expressive movements*. New York: Macmillan, 1933.
 3. Bandura, A. Psychotherapist's anxiety level, self-insight, and psychotherapeutic competence. *J. abnorm. soc. Psychol.*, 1952, 52:333-337.
 4. Barbara, D. A. The value of nonverbal communication in personality understanding. *J. nerv. ment. Dis.*, 1956, 123:286-291.
 5. Bindra, D. Psychotherapy and the recovery from neuroses. *J. abnorm. soc. Psychol.*, 1956, 53:251-254.
 6. Bordin, E. S. *Psychological counseling*. New York: Appleton-Century-Crofts, 1955.
 7. Brody, E. B. The treatment of schizophrenia: a review. In E. B. Brody & F. C. Redlich (Eds.), *Psychotherapy with schizophrenics*. New York: International Universities Press, 1952.
 8. Coleman, J. V. The initial phase in psychotherapy. *Bull. Menninger Clin.*, 1949, 13:189-197.
 9. Davidian, Elizabeth V. Rapport and the human element. *Personnel Guid. J.*, 1955, 33:469-470.
 10. Dymond, Rosalind F. A preliminary investigation of the relation of insight and empathy. *J. consult. Psychol.*, 1948, 12:228-233.
 11. Dymond, Rosalind F. A scale for the measurement of empathic ability. *J. consult. Psychol.*, 1949, 13:127-133.
 12. Eldred, S. H., et al. A procedure for the systematic analysis of psychotherapeutic interviews. *Psychiatry*, 1954, 17:337-346.
 13. Eysenck, H. J. The effects of psychotherapy: an evaluation. *J. consult. Psychol.*, 1952, 16:319-334.
 14. Eysenck, H. J. The effects of psychotherapy: a reply. *J. abnorm. soc. Psychol.*, 1955, 50:147-148.
 15. Fiedler, F. E. The concept of an ideal therapeutic relationship. *J. consult. Psychol.*, 1950, 14:239-245.
 16. Fiedler, F. E. A comparison of therapeutic relationships in psychoanalytic, nondirective and Adlerian therapy. *J. consult. Psychol.*, 1950, 14:436-445.
 17. Fieldler, F. E. Factor analyses of psychoanalytic, nondirective, and Adlerian therapeutic relationships. *J. consult. Psychol.*, 1951, 15:32-38.
 18. Fromm-Reichmann, Frieda. *Principles of intensive psychotherapy*. Chicago: University of Chicago Press, 1950.
 19. Giedt, F. H. Comparison of visual, content, and auditory cues in interviewing. *J. consult. Psychol.*, 1955, 19:407-416.
 20. Hahn, M. E., & MacLean, M. S. *Counseling psychology*. (2nd ed.) New York: McGraw-Hill, 1955.

21. Knight, R. P. Evaluation of the results of psychoanalytic therapy. *Amer. J. Psychiat.*, 1941, 98:434-446.
22. Krim, Elaine. A study in nonverbal communications; expressive movements during interviews. *Smith Coll. Stud. Soc. Work*, 1953, 24:41-80.
23. Luborsky, L. B. The personality of the psychotherapist. *Menninger Quart.*, 1952, 6:1-6.
24. Luborsky, L. B., Holt, R. R., & Morrow, W. R. Interim report of the research project in the selection of medical men for psychiatric training. *Bull. Menninger Clin.*, 1950, 14:92-101.
25. Manoil, A. Review of V.A. film on psychotherapeutic interviewing, Part IV, Nonverbal communication. *Contemp. Psychol.*, 1957, 2:116.
26. Maslow, A. H. *Motivation and personality*. New York: Harper, 1954.
27. Metzger, Emy A. Karen Horney on psychoanalytic techniques: understanding the patient as the basis of all technique. *Amer. J. Psychoanal.*, 1956, 16:26-31.
28. Orwell, G. *Nineteen eighty-four*. New York: Harcourt, Brace, 1949.
29. Patterson, C. H. *Counseling the emotionally disturbed*. New York: Harper, 1958.
30. Parloff, M. B. Some factors affecting the quality of therapeutic relationships. *J. abnorm. soc. Psychol.*, 1956, 52:5-10.
31. Phillips, E. L., & Agnew, J. W., Jr. A study of Rogers' "reflection" hypothesis. *J. clin. Psychol.*, 1953, 9:281-284.
32. Reik, T. *Listening with the third ear*. New York: Farrar, Straus, 1948.
33. Rogers, C. R. *Client-centered therapy*. Boston: Houghton Mifflin, 1951.
34. Rogers, C. R. *A theory of therapy, personality, and interpersonal relationships, as developed in the client-centered framework*. Chicago, 1956. (Mimeographed.)
35. Rogers, C. R. The necessary and sufficient conditions of therapeutic personality change. *J. consult. Psychol.*, 1957, 21:95-103.
36. Rogers, C. R. A process conception of psychotherapy. *Amer. Psychologist*, 1958, 13:142-149.
37. Rosenzweig, S. A transvaluation of psychotherapy: a reply to Hans Eysenck. *J. abnorm. soc. Psychol.*, 1954, 49:298-304.
38. Ruesch, J. Nonverbal language and therapy. *Psychiatry*, 1955, 18:323-330.
39. Ruesch, J. *Disturbed communication*. New York: Norton, 1957.
40. Ruesch, J., & Bateson, G. *Communication: the social matrix of psychiatry*. New York: Norton, 1951.
41. Ruesch, J., & Kees, W. *Nonverbal communication*. Berkeley: University of California Press, 1956.

42. Sanderson, H. *Basic concepts in vocational guidance*. New York: McGraw-Hill, 1954.
43. Sechehayé, Marguerite. *A new psychotherapy in schizophrenia*. New York: Grune & Stratton, 1956.
44. Seeman, J. A study of the process of nondirective therapy. *J. consult. Psychol.*, 1949, 13:157-168.
45. Shostrom, E. L., & Brammer, L. M. *The dynamics of the counseling process*. New York: McGraw-Hill, 1952.
46. Sinick, D. First name or last? *Personnel Guid. J.*, 1953, 31:527-528.
47. Snyder, W. U. An investigation of the nature of nondirective psychotherapy. *J. gen. Psychol.*, 1945, 33:193-223.
48. Snyder, W. U. (Ed.) *Casebook of nondirective counseling*. Boston: Houghton Mifflin, 1947.
49. Strupp, H. H. An objective comparison of Rogerian and psychoanalytic techniques. *J. consult. Psychol.*, 1955, 19:1-7.
50. Strupp, H. H. Psychotherapeutic technique, professional affiliation, and experience level. *J. consult. Psychol.*, 1955, 19:97-102.
51. Sullivan, H. S. *Conceptions of modern psychiatry*. Washington: William Alanson White Psychiatric Foundation, 1947.
52. Tudor, Gwen E. A sociopsychiatric nursing approach to intervention in a problem of mutual withdrawal on a mental hospital ward. *Psychiatry*, 1952, 15:193-217.
53. Tyler, Leona. *The work of the counselor*. New York: Appleton-Century-Crofts, 1953.
54. Williamson, E. G. *Counseling adolescents*. New York: McGraw-Hill, 1950.
55. Wolff, W. *The expression of the personality*. New York: Harper, 1943.
56. Woodworth, R. S. *Experimental psychology*. New York: Holt, 1945. Ch. 11.
57. Wyatt, F. The self-experience of the psychotherapist. *J. consult. Psychol.*, 1948, 12:83-87.
58. Zilboorg, G. Rediscovery of the patient: an historical note. In Frieda Fromm-Reichmann & J. L. Moreno. *Progress in psychotherapy*—1956. New York: Grune & Stratton, 1956.

CHAPTER 9

Transference and Countertransference

As rapport is an overworked word with counselors, so is transference among psychotherapists. Indeed, the indiscriminate use of these terms has led to their being considered to be, to some extent at least, synonymous. In this indiscriminate use of the term, transference is applied to the total relationship between the therapist and client. This total relationship is, however, sometimes referred to as "analytic rapport," to distinguish it from transference.

The varied use of transference is the result of differing opinions, or disagreement, as to what it really is. French (2, p. 73) writes that "there is a good deal of confusion as to what transference really means." Macalpine (32), in a comprehensive discussion, states that "there are no clear-cut definitions and many differences of opinion as to what transference is." She suggests that "transference is not fully understood; if it were, it could be stated simply and clearly."

In this chapter it is our purpose to describe the phenomenon of transference as it has developed in psychoanalysis, and to relate it to certain psychological concepts. Its significance in the client-centered approach to counseling and psychotherapy will then be considered, and a discussion of countertransference will conclude the chapter.

THE NATURE OF TRANSFERENCE

The concept of transference owes its origin to Freud. Freud first became aware of the relationship which he later described as transference when he was using the technique of hypnosis with his patients. A female patient, upon awakening from the hypnotic trance, threw her arms around him (17, pp. 47-48). Freud felt this to be "a false connection" to the person of the analyst. Later he used the term "displacement of affect" to refer to this phenomenon.

Freud defined transference in various, though essentially similar, ways. In one place (18, p. 139) he states that transferences "are new editions or facsimiles of the tendencies and phantasies which are aroused and made conscious during the progress of the analysis, but they have this peculiarity, which is characteristic for their species, that they replace some earlier person by the person of the physician. To put it another way: a whole series of psychological experiences are revived, not as belonging to the past, but as applying to the person of the physician at the present moment." Later definitions of other psychoanalysts are similar. Nunberg (38) states that "transference may be said to be an attempt of the patient to revive and re-enact, in the analytic situation and in relation to the analyst, situations and phantasies of his childhood." Lagache (29) specifies the situations of childhood as parent-child relationships in his definition: "Transference is generally defined as a repetition in present-day life, and particularly in the relationship to the analyst, of various emotional attitudes developed during childhood within the family and especially towards the parents." Hoffer (24) offers a somewhat more technical definition: "The term 'transference' refers to the fact that people when entering into any form of object-relationships and using objects around them for instinct gratification and for protection against anxieties (as a defense) *transfer* upon their objects those images which they encountered in the course of previous *infantile* experiences, and experienced with pleasure or learned to avoid

(pleasure-pain principle)." Finally, French (2, p. 73) stresses the inappropriateness of the patient's behavior, stating that "by transference we mean an irrational repetition of the stereotyped reaction patterns which have not been adjusted to conform to the present situation."

Transference, then, is not the total relationship between the analyst and the patient. It is only a part of it, that part which is irrational, i.e., not justified by the nature of the objective situation, or the actual behavior or personality of the analyst. The irrational reactions of the patient are repetitions of reactions to earlier figures, especially to parents or parent surrogates, in the patient's life. The repetition is usually "explained" by the concept of the repetition compulsion postulated by Freud to explain behavior not in accordance with the pleasure principle.¹ Affects and emotions, conflicts, attitudes, wishes, fantasies, and ideas originally directed toward earlier significant figures are displaced onto, or transferred to, the analyst.

While there are some analysts who would prefer a broader definition of transference, most agree with the definition just given. Most would limit transference to the irrational behavior of the patient toward the analyst. But recently there have been a number of analysts who have raised a question about how much of the presumed irrational behavior is actually irrational. It has usually been held that transference reactions are not related to the analytic situation or the analyst's behavior, but arise spontaneously within the patient. Freud (17, p. 76) wrote: "It must not be supposed, however, that transference is created by analysis and does not occur apart from it. Transference is merely uncovered and isolated by analysis." Again, he states (16, p. 382) that ". . . we do not believe that the situation in the cure justifies the genesis of such feelings." Ferenczi, Sandor, Rado, and others of the classical or

¹ Lagache (29), recognizing the lack of explanation in the repetition compulsion, suggests that it is related to the Zeigarnik effect, or the fact that interrupted tasks are better remembered, and taken up again more actively, than completed tasks. Similarly, unresolved infantile conflicts are reopened in the analytic relationship.

orthodox analysts accepted this point of view. Alexander (1, p. 46) states that transference behavior occurs "without the analyst's giving any provocation."

The analyst has traditionally been considered as a mirror, a neutral, objective, anonymous figure. In the last few years, however, it has become recognized that this conception of the analyst cannot be maintained. Macalpine (32) was among the first to point this out. She regards the transference as being induced from outside the patient, by the analytic situation and the analyst's behavior. She notes that Freud himself once stated that the analyst "must recognize that the patient's falling in love is induced by the analytic situation," though he never elaborated or followed up this statement.

Macalpine (32) specifies the elements of the analytic situation which create an infantile setting and a threat to the patient to which the patient adapts by regression to an infantile state, which is the transference. These features include: (1) the curtailment of the object world, by the use of the couch, which limits vision, even leads to closing of the eyes, and requires an infantile posture; (2) the constancy of the environment, which fosters fantasy; (3) the fixed routine which is reminiscent of infantile care; (4) the lack of response from the analyst, which is a repetition of infantile situations; (5) the interpretations on an infantile level; (6) the reduction of ego function to a state intermediate between waking and sleeping; (7) the diminished personal responsibility in the analytic sessions; (8) the elements of magic, infantile in nature, in the patient-physician relationship; (9) the liberation of fantasy from conscious control in free association; (10) the authority of the analyst inherent in the situation; (11) the disillusionment of the patient's expectation that he will be dependent on and loved by the analyst, leading to regression; (12) the inability to select and guide thoughts, a facet of infantile frustration; (13) the frustration of every gratification by the analyst, leading to regression; (14) the resulting divorce from the reality principle, and

regression to the pleasure principle. These conditions cannot help but produce regression to an infantile state. As Spitz (53) puts it, the patient is forced into the position of a child. Waelder (56) points out that the patient is in the position of a child coming for help, and that by exposing the most intimate aspects of his life he is put "in the position of the child that is nude in the presence of adults" (see also Schmideberg [51]).

From this point of view, the transference is the patient's adaptation to a real situation, an adaptation that demands regression to an infantile level. Macalpine (32) thus defines transference as a "person's gradual adaptation by regression to the infantile analytic setting."

Transference, then, is the result of the nature of the analytic situation, and thus can be induced or controlled by the behavior of the analyst. As Greenacre (21) states it, "The [transference] relationship is an artificial one, arranged and maintained for the definite purpose of drawing the neurotic reactions into sharp focus and reflecting them upon the analyst and the analytic situation." Nevertheless, the patient contributes to the development of the transference by a readiness and willingness to adapt to the analytic situation. He comes to the analyst for help, thus placing himself in the hands of the analyst, accepting a dependent position. Moreover, he regresses easily because, presumably, the origins of his conflicts lie back in the infantile experiences.

If the transference is induced, or at least fostered, by the analytic situation, then it would appear that it could be controlled, or even avoided, by the therapist. This is essentially the approach of Alexander and French (2) in their brief psychoanalytic therapy. Transference, in the technical psychoanalytic sense which has been discussed above, is not inevitable in psychotherapy, and may be undesirable in many cases. Alexander and French agree that it is possible for a patient to find permanent relief from symptoms by using the therapeutic relationship in a rational, realistic way. Transference is avoided, or controlled, by decreasing the patient's

dependence on the therapist. Less frequent interviews is one way which they suggest. Other ways presumably would include dispensing with the couch, having the patient face the therapist, keeping interpretations on a current level, abandoning the technique of free association, etc. One of the techniques of Alexander and French is for the therapist not only to avoid being a blank screen to whom the patient transfers attitudes and feelings, but to have the therapist take an active role, in which he behaves toward the patient in a way opposite from the way the father, or other authority or traumatic figure, treated him. Presumably, however, such a situation, while it may be psychoanalytic therapy (since it is based on psychoanalytic dynamics or personality theory), is not psychoanalysis (1, p. 161). The main work of psychoanalysis is considered to be the analysis of the transference. Zetzel (62) suggests that in spite of differences of opinion regarding transference, "analysis of the infantile oedipal situation in the setting of a genuine transference neurosis is still considered a primary goal of psychoanalytic procedure. An essential difference between analysis and other methods of therapy depends on whether or not interpretation of transference is an integral feature of technical procedure." Transference, then, while first seen by Freud as constituting a resistance to analysis, was also recognized as an asset in that it brought into therapy the essential, original, and basic conflicts or neurosis. The difficulty of this analysis of the transference accounts for the length of psychoanalysis, and for what have been called interminable or unending analyses (2, 37). Macalpine (32) feels that the resolution of the transference is not understood, and that it actually must resolve itself after analysis.

There are analysts, however, who do not accept the infantile origin of the transference relationship (26, 28, 46, 54), or indeed that all neuroses or emotional disturbances originate in infantile conflicts. Horney (26) is probably the most outspoken advocate of the position that transference is not a reaction to the past, but an expression of the patient's present personality and conflicts.

Glover (20) also suggests that "the patient displaces on the analyst *all* he has ever learned or forgotten throughout his mental development." It appears that Ferenczi and Rank (14) anticipated the position of Horney. They felt that since much of the child's early experience occurs in the preverbal period, it could not be recollected and verbalized. They therefore proposed analysis of the existing transference without the necessity of the recollection and reëxperiencing of childhood conflicts, or the so-called lifting of infantile amnesia.

Dependence on the analyst is the result of basic anxiety, according to Horney. Interpretation in terms of infantile patterns, she warns, has three dangers: (1) it contributes to the dependency, since it doesn't touch the underlying anxiety, and thus counteracts the goal of therapy which is independence; (2) the analysis as a whole may become unproductive; and (3) there may be insufficient elaboration of the patient's actual personality structure. The purpose of analysis is the understanding of present personality trends, not of their relationship to childhood. She raises the interesting question if in analysis "love is a feeling which is only transferred from an infantile object to the analyst, is it perhaps true that all love is transference, and if not, how can we distinguish between love which is transferred and love which is not?" (26, p. 162).

Horney recognizes that the patient reacts to the therapist in terms of his own conflicts and needs, his own personality patterns, rather than entirely in terms of the therapist's objective personality and behavior. This, however, is not transference as it is defined by orthodox psychoanalysis. The question which she voices raises an important point—is all transference behavior neurotic, and if not, when is it not? This problem is perhaps related to the confusion between the transference relationship and the transference neurosis. It is difficult to find a distinction between them, but the terms are not always used interchangeably. Some limit the use of transference to the transference neurosis. French gives definitions for both terms, but they appear to be identical (2, ch. 5). Irrational

elements in the patient-analyst relationship are termed neurotic, yet the transference is defined as irrational behavior. Macalpine (32) defines the transference neurosis as the adapted, regressed condition, the end point of transference prior to its working through. The question still remains, however, as to whether the transference relationship is entirely an abnormal, neurotic phenomenon.

TRANSFERENCE AND GENERALIZATION

That transference is not limited to the analyst-patient relationship has been recognized by a number of psychoanalysts. The definitions by Lagache (29) and Hoffer (24) implicitly recognize this. Nunberg (38) specifically states that "transference occurs also in other than psychoanalytic therapies," and further states that the transference of infantile experiences into reality and acting them out is not limited to the transference situation, but is a "tendency to establish identity of old and new perceptions." Greenacre (21) similarly suggests that a dependency relationship, and thus transference, will develop in any situation where one person is seeking help from another, trained person. Thompson (54) begins her discussion of transference with the statement: "Transference was not created by psychoanalysis. As long as human beings have had relationships with each other, there have probably been irrational elements in those relationships. These irrational elements have been especially marked in the attitudes toward those upon whom a person is dependent. Therefore, one sees it in all situations where one of the two people is in a position of authority in relation to the other." As French (2, p. 72) reminds us, "all behavior is patterned upon the past, is based upon experience," so that all behavior has past, or unreality, referents as well as present, reality referents.

This suggests a relationship between transference and what has been dealt with under the concept of "transfer of training" in psychology. The similarity in terms, while perhaps purely coinci-

dental in their origins and development, is significant. Transference is behavior which is affected by past experience; it is reacting in a new situation on the basis of habits learned in a previous situation. Even the use of the terms positive and negative to apply to both transference and transfer of training is parallel. In positive transference the patient reacts appropriately to a helping figure, and the relationship is facilitated because of this application of past learning. In negative transference, as in negative transfer of training, the patient reacts inappropriately to the present reality situation, using behavior learned in another, differing situation.

All adult behavior is based in part on previous learning. In a new situation, reactions are not entirely random or trial and error in nature, but are chosen from the repertoire of learned behavior and are more or less appropriate to the situation. The individual tends to respond as he has in the past to similar—or better, to similarly perceived—situations. His behavior is appropriate or inappropriate, depending on the similarity of the new situation to past ones, and on the accuracy of perception of the individual. In other words, individuals tend to generalize from previous learning. Transference, then, is a special case of the phenomenon of generalization. Miller (34) has suggested this in an interesting paper.

Now it is true that generalization may be faulty; the perception of the new situation may be false. (This situation will be discussed in the following section.) But it also happens that adequate generalization may not occur because of the interference of persistently established behavior reactions. Such reactions are the basis for Freud's concept of the repetition compulsion. Failure to generalize from appropriate earlier experiences, or failure to learn to react as the present situation demands, may be due to the persistence of inappropriate responses which have become fixated in the individual's behavior. This is the neurotic paradox described by Mowrer (36), the persistence of "behavior which is at one and

the same time self-perpetuating and self-defeating" (36, p. 487), a contradiction of the law of effect or the theory of reinforcement. This is not the place to evaluate resolutions of this paradox, which led Freud to the repetition compulsion. But the work of Maier (33) is suggestive. He found that, when forced to face an insoluble problem, rats developed rigidly fixed patterns. And, as suggested above, and in an earlier chapter (Chap. 7), behavior is determined by the *perception* of the situation, rather than its "real" characteristics. This leads to a consideration of some of the determinants of perception.

TRANSFERENCE, PERCEPTION, AND PROJECTION

The influence of needs upon perception has long been recognized in common sense psychology. Extreme hunger and thirst lead to preoccupation with food and drink, and even to mirages, which are false perceptions. Only recently have psychologists investigated this area, however. Among the earliest studies were those of Sanford (49, 50) and Murphy and his students (30, 42, 52). Since 1947 Bruner (10, 11, 41) has stimulated a great deal of work on this problem, including a symposium published by Blake and Ramsey (6). Although there have been controversies over some of the methods and procedures, there seems to be no doubt that personal values and needs affect perception.²

The mechanism by which needs and values affect perception is called projection. Projection has been used in a number of different ways. In a technical psychoanalytic sense, projection is the attribution, ascription, or attachment to another person of motives, desires, wishes, attitudes, etc., which belong to, but are unacceptable to, oneself. It is thus reacting to one's own dynamic tendencies as though they belonged to someone else, and is an unconscious, defensive process.

Projection is used in other ways, however. Several discussions of transference have employed the term. Nunberg (38), for example,

² For a recent review of this work, see Jenkin, Noël. Affective processes in perception. *Psychol. Bull.*, 1957, 54:100-127.

discusses transference as a projection of the image of the father on the analyst. Zetzel likewise (62) writes that the analyst is viewed "as a substitute by projection for the prohibiting parental figures." Greenacre (21) also uses the term. The use of projection by these writers is not consistent with the usual psychoanalytic definition given above. Schmideberg's (51) example of a child's fear of attack by the analyst as a projection of her own sadism is in agreement with the definition, however. Since the sadism is not actually present in the analyst, this is a transference reaction. But transference is, as Paulsen (40) points out, more than projection as it is usually defined in psychoanalysis. The viewing of the analyst as the father, or other authority figure, and endowing him with the attributes of these figures, is displacement rather than projection.

But the term projection is frequently used in a broader sense. Freud himself defined it once as follows:

The projection of inner perceptions to the outside is a primitive mechanism which, for instance, also influences our sense-perceptions, so that it normally has the greatest share in shaping our outer world. Under conditions that have not yet been sufficiently determined even inner perceptions of ideational and emotional processes are projected outwardly, like sense perceptions, and are used to shape the outer world, whereas they ought to remain in the inner world.³

Thus broadly defined, projection would appear to include displacement, and thus transference. It is also in this broad sense that projection has been used to apply to certain tests, such as the TAT and Rorschach. In projective techniques, the subject responds to the test stimuli in terms of his own perceptions as influenced by his motivations, attitudes, and drives. The meanings or interpretations which he attributes to the stimulus are projected into it. In this sense, all perceptions, since they are influenced by these inner factors, involve projection. The perceptions of the therapeutic interview and of the therapist are no exceptions. What the client

³ *The basic writings of Sigmund Freud*. A. A. Brill (Ed.) New York: Random House, 1938, p. 857. Quoted in reference 3, p. 1.

sees in the therapeutic situation depends in part on the personal meanings which he projects into it.

Estes (13) states that there are two objective conditions which determine whether a personally significant recurring experience or situation will be responded to realistically, in terms of its objective characteristics. These are its clarity or absence of ambiguity, and its consistency. The characteristic of ambiguity is the structured-unstructured dimension in projective tests.

Bordin (7, 8) has provided an excellent treatment of ambiguity as a dimension of psychotherapy. He defines ambiguity as the stimulus configuration which is vague and incomplete, and in which no clear-cut response is predetermined. Ambiguity "is that attribute of a stimulus situation by virtue of which its demand character on different persons is different" (8, p. 138). In the therapeutic relationship the therapist may define or structure the situation in varying degrees. The more unstructured, or ambiguous, the situation, the more opportunity it gives for projection by the client, or for structuring it in terms of his needs, values, and conflicts.

The psychoanalytic situation is highly ambiguous, as both Estes (13) and Bordin (7, 8) point out. The analytic rule of free association—"tell me everything that comes to your mind"—carries no restrictions. The analyst is silent for long periods, giving the impression of a blank screen. In the orthodox use of the couch, he is out of view of the patient and therefore not present as a reality in the visual field of the patient. These conditions maximize the opportunity for projection on the part of the patient, for the development of irrational or unrealistic perceptions—in other words, for the development of transference. Whether the transference involves infantile regression, or is of the type described by Horney, depends upon how the analyst structures the situation. Where the situation is structured as one where infantile, regressed behavior is demanded, it is inaccurate to label this behavior as

purely transference, or due to projection; it is a realistic response to the situation. The fact that the patient does regress, however, indicates the presence of unresolved infantile conflicts. Presumably, if this is the case, patients who are unable to adapt to an infantile relationship may not have such conflicts.

Bordin (7, 8) lists as one of the functions of ambiguity this eliciting of the client's conflicting feelings, and states that this is identical with the concept of transference. The eliciting of these emotions enables the therapist to understand the client better. Finally Bordin suggests that by being ambiguous the therapist provides a background against which the client's irrational feelings become clear and come into awareness.

Both Estes and Bordin warn that ambiguity tends to arouse anxiety. The latter warns against inexperienced counselors using it in extreme form. Although he feels that client-centered therapy is less ambiguous than psychoanalysis, he claims that he has seen inexperienced counselors, in the effort to be nondirective, become involved in intense relationships fraught with danger to the client. While this may be possible, most beginning counselors are unable to achieve such ambiguity, since, as Bordin also points out, an ambiguous situation is anxiety-provoking to the therapist.

Faulty generalization, or the persistence of fixed, inappropriate behavior, may be a matter of the "false" perception of the situation.⁴ This "false" perception arises on the basis of the individual's values, needs, or unresolved conflicts. But it is also a function of the ambiguity of the situation or stimulus. The motive behind these false perceptions which lead to nonadaptive behavior are not entirely clear. These behaviors are commonly regarded as defense mechanisms. The phenomenological point of view adopted in this book would suggest that such behavior represents efforts toward the preservation of the self in the face of threat. Threat, it has been suggested (Chap. 7), leads to withdrawal and reduction

⁴ See Chapter 11 for a discussion of perception and "misperception." A "false" perception is essentially an idiosyncratic perception.

in the variability of behavior. Under threat, the individual's perceptions are more strongly influenced by his needs.

Estes advocates the avoidance of ambiguity, apparently feeling that clarity and consistency are conducive to differentiation and accurate experience. "To the extent that the therapist and the therapeutic task and situation are clear and consistent, to that extent the client should progressively respond to the therapist realistically. To state the principle more generally, when a contemporary, recurrent situation is clearly and consistently differentiated from earlier situations to which it at first gets assimilated, a perceptual conflict is instigated. And it tends to be resolved realistically" (13). The clear differentiation of the present therapeutic situation from the earlier infantile situation is one of the techniques used by Alexander and French (1). Ambiguity, or transference, then, is not only unnecessary, but undesirable in psychotherapy. Estes feels that client-centered therapy is a clear, consistent therapeutic situation.

TRANSFERENCE AND CLIENT-CENTERED THERAPY

The psychoanalytic transference does not often occur in client-centered therapy. The client-centered therapeutic situation is such that it does not foster transference. It is less ambiguous than psychoanalysis—the client sits up, facing the therapist; the rule of free association is not applied; and there is perhaps less silence on the part of the therapist in the early interviews. Nor does the client-centered relationship foster an attitude of dependence in the client. The therapist does not assume, or imply, either by actions or words, that he is a superior or authority figure. The whole atmosphere of the client-centered situation encourages and fosters independence in the client, rather than dependence. Even the avoidance of interpretation contributes to this development of independence in the client (47, pp. 214–215). Most therapies stress the need for the therapist's understanding the client better than the client does himself, keeping at least one step ahead of the

client. Wyatt (61) relates this to transference: "Transference can only develop when the therapist has succeeded in showing that he understands the patient more effectively than the patient does himself." This attitude, Rogers feels (47, pp. 215-216), leads to loss of self-confidence in the client, and to a dependent relationship.

Another factor fostering the transference is a threatening situation. Therapy in general, including psychoanalysis, has commonly been held to be a nonthreatening situation. Nevertheless, the analytic situation, as detailed by Macalpine (32) contains threatening elements. She relates this threat and insecurity to the regression which is an essential of orthodox transference. Analysis, by fostering, even forcing, regression and dependence, creates resistance and conflict, if only regarding the dependent-independent needs of the client. And as we have seen, ambiguity is threatening, leading to anxiety. Client-centered therapy, on the other hand, is less threatening and more secure, with its avoidance of interpretation, less ambiguity, and encouragement of independence rather than dependence and regression.

Transference, then, develops in a situation where the therapist is a superior, authoritative figure, and the client is made to feel inferior and childlike. A dependence of the client on the therapist naturally results. A threatening and insecure situation fosters regression and leads to defensiveness (resistance), which encourages projection and misperception of the actual situation.

Transference can and does develop to some extent in many client-centered therapy experiences, however. It will be remembered that transference is a function of the client and the situation. To the extent that client-centered therapy is ambiguous, transference may and does develop. Clients may be more or less "ready" to develop a transference relationship. This readiness is perhaps related to the nature and severity of their maladjustment or disturbance. As Rioch (46) points out, strong, repressed feelings seek emotional discharge or expression regardless of reality. Even in a relatively clear and unambiguous situation, the client with

strong emotional attitudes will tend to project them into the situation. A highly dependent client may be ready, even desirous, of a transference relationship and convert the therapist into a father-figure. Rogers (47, pp. 197-217) refers to transference "attitudes" in connection with client-centered therapy.

When transference attitudes, or a transference relationship, do develop in client-centered therapy, what does the therapist do? The analyst, as has been indicated, analyzes and interprets the relationship, as he does other productions of the patients. As the analyst treats transference as he does other responses of the patient, so the client-centered therapist accepts and understands these attitudes and feelings just as he does any other attitudes of the client (47, p. 203).

This handling of transference attitudes in the atmosphere of client-centered therapy appears to lead to relatively rapid recognition by the client that their origins are within himself, rather than in the therapist or in the therapeutic situation. That is, in a secure, nonthreatening, relatively unambiguous or reality-oriented situation, the client is led to recognize that projection (or displacement) is occurring. Reality, though inconsistent with the original perception, can be accepted. Rogers gives some illustrations of this (47, pp. 201-213). In some severely disturbed clients, where there is present a strong internal threat to the self, projection may be greater and more persistent.

The point of view of client-centered therapy regarding transference is as follows: (1) transference is not a necessary condition for psychotherapeutic personality change; (2) in the client-centered approach, the orthodox psychoanalytic transference does not develop; (3) transference attitudes do often develop, but are handled as are other attitudes expressed by the client.

If the transference, with its regression to an infantile, dependent level, is not necessary for therapeutic change, then does this mean that maladjustment does not originate in infancy? Or does it rather mean that it is not necessary to uncover and analyze these

origins, to recover infantile amnesia? The latter would seem to be the more tenable position. This is the position of Horney and other neoanalysts, who are concerned with current interpersonal relationships. If, then, client-centered therapy and neoanalytic therapy are similar in concentrating on current adjustment problems, how do they differ? Why is it that in one approach the transference relationship is strong and is considered to be an essential factor, whereas in the other approach it is not? It appears that the nature of the therapeutic situation still differs, in the same way in which client-centered therapy differs from orthodox psychoanalysis. The analytic situation, even in the case of the neoanalysts, appears to be one in which a dependence on the therapist is fostered, if by no other technique than that of interpretation, even though Horney criticizes the dependency of orthodox analysis.

Finally, then, how does client-centered therapy differ from brief psychoanalytic psychotherapy as advocated by Alexander and French (2), where transference is not involved? In this latter approach, transference and dependence are avoided or controlled. Nevertheless, the basic technique is interpretation, coupled with role-taking and other activity on the part of the therapist, which would appear to lead to the development of a dependency even if not the orthodox transference. And the relationship is still apparently one of superiority-inferiority, with the therapist being an authority. The total picture of brief psychoanalytic therapy is one of the therapist keeping ahead of the client, outthinking, outwitting, and outguessing him, actively directing and manipulating him.

As has been suggested earlier, all behavior is based on past experience, as well as being influenced by the present situation. The client's behavior is thus a mixture of irrational, projected elements—errors in perception and/or generalization—and of realistic reactions. The separation of these two elements is difficult, if not impossible, even though French (2, chp. 5) insists that the trans-

ference neurosis and reality adjusted behavior are mutually exclusive. It would appear to be difficult for a therapist to determine whether the client's reactions are in some cases responses to his (the therapist's) actual personality, or to projections upon the therapist. Heimann (23) cautions that "the analyst has to consider the reciprocal fact that his own personality, no matter how much he controls its expression, is perceived and reacted to by the patient." It is difficult for the therapist to be aware of his own personality sufficiently well to know whether the client is reacting to him as he is or as he is misperceived, particularly since every reaction combines the two. Only a true mirror will give back a true reflection. The apparent error of psychoanalysis in insisting that the transference is entirely a spontaneous reaction of the client would indicate how easy it is to misinterpret the client's behavior. This leads us to a consideration of countertransference.

COUNTERTRANSFERENCE

Compared to the discussion of transference, there is relatively little concerning countertransference. Perhaps, as Racker (44) suggests, neglect has been due to the rejection by analysts of their own problems, problems surviving the didactic analysis which Freud originated as a result of his discovery of countertransference. The assumption was that countertransference was not present unless the analyst was not completely analyzed; if the analyst felt he should not have countertransference attitudes or feelings, he would suppress them. This assumption has now given way to the recognition that countertransference is present in all analytical situations. The development of interest in the countertransference has come perhaps as a result of the recognition that the analyst is not, and cannot be, neutral and objective, a mirror or a screen. Nor is the analyst, however well analyzed, free from transference reactions to the client. Racker (44) refers to the analytic myth "that the analysis is an interaction between a sick person and a healthy one." When the analyst ceased to be a blank

screen for the patient, the patient ceased to be an abstract problem to the analyst, and became the object of stronger feelings.

As transference consists of irrational reactions of the patient to the therapist, so countertransference consists of irrational reactions of the therapist to the patient. This is included in most definitions of the term. However, like transference, countertransference has been variously described and defined (12, 15, 19, 31, 39, 44). As transference has been applied to all the reactions of the patient to the analyst, so countertransference has been used to include all reactions of the analyst to the patient. Racker (44), in a comprehensive discussion of countertransference, accepts it as "the totality of the analyst's psychological responses to the patient." Heimann (22) also agrees with this definition. At the other extreme, it has been limited to "repressed elements, hitherto unanalyzed, in the analyst himself which attach to the patient in the same way as the patient transfers to the analyst affects, etc., belonging to his parents or to the objects of his childhood; i.e., the analyst regards the patient (temporarily and varyingly) as he regarded his parents" (31). However, there has been less tendency to restrict countertransference to this reaction than there has been to restrict the definition of transference. Possibly the cases in which the analyst reacts to the patient as if the patient were his father are rare, certainly much rarer than the reverse. This is to be expected in view of the fact that the analyst is often, if not usually, older than the patient, and, if not older, is an authority figure because of his profession and status, at least in the eyes of the patient. It is curious that little attention has been given to the situation in which the analyst views the patient, irrationally, as a son.

Most discussions of countertransference clearly state, or imply, that the transference reactions of the analyst to the patient are few and weak compared to those of the patient to the analyst. This may be so in analysis, if not in other forms of therapy. It is perhaps to be expected, since the analyst has been analyzed himself, and is presumably more mature, if not older, than the patient.

Berman (5) states that because of the training analysis, the attitudes and emotional responses of the analyst will be less intense and shorter in duration than those of other persons.

Nevertheless, the extent and significance of the emotional reactions of the analyst to the client have been increasingly recognized, and although these reactions vary in nature, they have tended to be included as countertransference reactions. There have been several discussions by psychoanalysts, including those of Heimann (22), Little (31), Reich (45), Cohen (12), Gitelson (19) and Racker (43, 44), which are of value to all therapists. Although transference appears to constitute less of a problem in other therapies than in analysis, countertransference, broadly defined as unwarranted or excessive attitudes or emotional reactions toward the client, is a significant problem in all therapies. This has already been touched upon in Chapter 3, when we discussed the influence of the therapist's needs upon the therapeutic relationship as an ethical problem. It is not possible to deal exhaustively with the problem here, and the reader is encouraged to consult the articles on countertransference referred to in this section.

We shall, however, give some consideration to how the therapist can recognize and deal with his own emotional reactions in therapy. Like transference, countertransference is viewed by analysts as being both a danger and an asset. Though it would appear to be more often a hindrance, recently it has been viewed as a help, but its use has not been adequately described or explored.

Since the needs which the therapist may be satisfying in the therapeutic relationship do not usually reach awareness, how can the therapist become aware of them? Sometimes, of course, they are accompanied by strong or clear feelings. This suggests that the therapist should examine any strong or unusual emotions arising within himself during therapy. The development of a strong liking for or dislike of the client should be examined. On the one hand, the therapist may be identifying with the client, so that

empathy has become sympathy. On the other hand he may be irritated and impatient at the lack of progress of the client, which may be threatening his concept of himself as a successful, competent therapist. Reactions of love or hate may or may not be related to the actual personality or behavior of the client, but in any case they should be examined.

Again, strong emotional reactions of the client should not be accepted automatically or interpreted as transference reactions. The therapist should examine himself to see if his own personality or behavior has aroused the reaction. Since we see what we want to see, in therapy, as in other situations, it is too easy to attribute the client's reactions to the transference rather than to examine them in terms of one's own personality and behavior. The therapist may be projecting his own ideas and needs into the client's behavior. Benedek (4) points out that the client may make valid responses to the therapist as a person, which the therapist labels as transference because to accept them would compel him to give up his position as an impersonal agent, or screen.

We see then that both the client's and therapist's emotional reactions must be examined in terms of being reality responses to each other and must be understood as such for progress in therapy. Cohen (12) suggests in this connection that "perhaps the loss of the feeling that communication is going on is the most commonly used signal which starts the analyst on a search for what is going wrong," a search which begins with himself. She suggests a useful definition of countertransference for all therapists: "When, in the patient-analyst relationship, anxiety is aroused in the analyst with the effect that communication between the two is interfered with by some alteration in the analyst's behavior (verbal or otherwise), then countertransference is present." She classifies anxiety-arousing situations into three categories. The first includes situational factors, or reality events, in the analyst's life, including the need for success or recognition as a competent therapist. Current problems or frustrations would also be included here, as well as fears

of failure, or of a psychotic break or suicide of the patient. The second category includes unresolved neurotic problems of the therapist. The third consists of the communication of the patient's anxiety to the therapist, by verbal or nonverbal means.

The presence of countertransference attitudes may thus be identified by anxiety to which the therapist should be alert. Cohen's signals of anxiety are useful, and are included, slightly reworded, here:

1. Unreasonable dislike for the client.
2. Inability to empathize with the client, who seems unreal or mechanical.
3. An overemotional reaction to the client's hostility.
4. Excessive liking for the client.
5. Discomfort with the client; dread of sessions with him.
6. Preoccupation with client's behavior trends, including fantasizing about responses to the client.
7. Difficulty in paying attention to the client, with mind wandering to personal affairs, or drowsiness.
8. Beginning appointments late, or running over the established time.
9. Getting involved in arguments with the client.
10. Defensiveness or vulnerability to the client's criticism.
11. Repeated misunderstanding of the therapist by the client, or disagreement with his responses.
12. Provoking affect in the client.
13. Overconcern about the confidential nature of his work with the client.
14. Sympathy with client regarding his treatment by others.
15. Feeling impelled to do something active for the client, such as giving advice or suggestions.
16. Appearance of the therapist in the client's dreams as himself, or the appearance of the client in the therapist's dreams.

When the therapist recognizes the presence of excessive or unjustified emotional reactions to a client, what should he do about it? Most discussions of countertransference regard it as detrimental to therapy. As Alexander expresses it, "So far as the countertransference is concerned, the prevailing view is that the analyst's own emotional reactions to the patient should be considered as a disturbing factor. It is a kind of unavoidable impurity" (1, p. 82). The goal, then, is to minimize this impurity.

This is the purpose of the training analysis. The aim is to attempt to approach the ideal of the analyst as a blank screen, with the analyst's personality minimized if not eliminated, so that the patient's reactions can be, as purely as possible, transference reactions. The analyst, therefore, should be aware of his countertransference reactions in order to control them, in the attempt to achieve objectivity and a neutral, detached attitude, even though "this detached attitude is, of course, studied and not quite spontaneous because even the well-analyzed therapist retains certain characteristic reactions to other persons" (1, p. 85). But "quite often the analytic process becomes stymied on account of the inexperienced student's lack of ability to control his spontaneous countertransference attitudes" (1, p. 89). Alexander continues: "The analyst should attempt to replace his countertransference reactions with attitudes which are consciously planned and adopted according to the dynamic exigencies of the therapeutic situation" (1, p. 93). Though a completely objective attitude is unattainable, it should be striven for, even though the result is a studied, controlled relationship rather than a spontaneous one.

This point of view regarding the handling of countertransference attitudes has been questioned recently, and Alexander himself recognizes the possible potential value of a different approach to the use of countertransference. This new approach is based on the fact that actually the countertransference cannot be controlled by the therapist. It is not easy, or perhaps possible, for the therapist to conceal his emotional reactions from the client. The reactions are sensed by the client. The personality of the therapist cannot be kept out of therapy by control or role-playing.

Some analysts have stressed the use of the countertransference as a tool or instrument in psychotherapy (e.g., 4, 12, 22, 31, 44, 58). Cohen (12) and Racker (44) suggest that understanding the origins of countertransference attitudes may aid in understanding the client's transference. Benedek (4) and Little (31) suggest that the countertransference be analyzed, the latter suggesting that

the analyst discuss his countertransference reactions with the client. There is little, however, of a very specific nature regarding the actual use of countertransference as a tool.

Of more significance, perhaps, are some reports of experiences resulting from the actual expression of the therapist's emotions in the therapeutic situation. Weigert (58) gives an illustration of the expression by the therapist of disappointment and anger in therapy, without the loss of good will toward the client. Alexander (1, pp. 90-91) reports that "an inadvertent expression of my resentment against the patient's provocative attitude had an unexpected therapeutic result." When the patient said: "Do you deny that you dislike me and do you call it analysis being impatient with your patient?" the therapist admitted the dislike, while pointing out that the patient's behavior was unconsciously calculated to make him disliked. Alexander, however, regards this as a loss of the control which is so important in psychoanalytic therapy. He considered the favorable results in this case only an accident. Only by chance would a spontaneous expression of a countertransference reaction be beneficial.

Weigert (58) feels that the countertransference can be used as an instrument for determining the progress of therapy. The resolution of the countertransference permits the analyst to be emotionally more free and spontaneous with the patient, until "The analyst is able to treat the analysand in terms of equality."

But why should not the therapist be free and spontaneous throughout the therapy? This attitude toward the therapist's participation in the therapeutic relationship, perhaps first suggested by Ferenczi, but opposed by Freud, is being expressed again by the Sullivanian school of analysts. Thompson (55) writes that "The analyst need no longer feel defensive about being natural and spontaneous."

Warkentin (57) gives some illustrations of the introduction of the therapist's feelings, including aggression, into therapy, stating that "on occasion it is even helpful when the therapist offers

directly his aggressive or negative, as well as his positive attitude to the patient." He suggests that "the patient may more readily accept the therapist's positive feeling, when there is no withholding of other emotions as they are experienced by the therapist." He reports the case of a school teacher, giving an "excellent history," to whom he said: "You are beginning to irritate me with your empty smile and friendliness; I wish you felt free to be more honest with me." This may seem to be inconsistent with the attitude of acceptance and a nonthreatening therapeutic atmosphere. Possibly in extreme form it is, even though it is based on sincerity and frankness. Warkentin appears to use the method as a technique with selected patients, and stresses that there must be no question of the genuine acceptance of the patient, and that the statements must be an honest expression of the therapist's emotional experiences at the time.

Possibly the control of countertransference attitudes introduces an artificial element into therapy, contributing, as does the classical transference on the part of the client, to the length of analysis. The control of the countertransference may be an important element in the development of the transference, and in the establishment of an authority-dependency, superior-inferior relationship.

Rogers (48) recently has raised a similar question regarding the participation of the therapist. He uses the term "congruence" to cover in effect what has been considered to be freedom from countertransference, or awareness of the therapist of his true emotional reactions. "Thus, if he is experiencing threat and discomfort in the relationship, and is aware only of an acceptance and understanding, then he is not congruent in the relationship, and therapy will suffer. It seems important that he should accurately 'be himself' in the relationship, whatever the self of that moment may be." Then he continues, "Should he also express or communicate to the client the accurate symbolization of his own experience? The answer to this question is still in an uncertain state. At present we would say that such feelings should be ex-

pressed, if the therapist finds himself persistently focussed on his own feelings rather than those of the client, thus greatly reducing or eliminating any experience of empathic understanding; or if he finds himself experiencing some other feeling than unconditional positive regard" (48, pp. 42-43).

The therapeutic relationship is a complex one. Both therapist and client are reacting to each other in terms of varying degrees of reality, and projection, or transference. Each is reacting to the other in terms of perceptions and misperceptions, and to the perceptions and misperceptions which the other has of him. It is no wonder then, that the relationship is complex, and its analysis difficult and often confusing. It is no wonder that misunderstandings develop in the relationship.

A necessary condition of therapeutic change is the presence of understanding, which is based on successful communication. Anything which clears the channels of communication is therefore desirable. The therapist must continually keep in mind the necessity for communication and mutual understanding in deciding what he shall introduce into the therapeutic situation in terms of his own feelings and reactions. It would appear that where the suppression or control of these feelings impedes communication, they should be expressed in some form. It is possible that spontaneity on the part of the therapist is an important aid in developing and maintaining a condition of communication and understanding.

REFERENCES

1. Alexander, F. *Psychoanalysis and psychotherapy*. New York: Norton, 1956.
2. Alexander, F., & French, T. M. *Psychoanalytic therapy*. New York: Ronald, 1946.
3. Bell, J. E. *Projective techniques*. New York: Longmans, Green, 1948.
4. Benedek, Therese. Dynamics of the countertransference. *Bull. Menninger Clin.*, 1953, 17:201-208.
5. Berman, L. Countertransference and attitudes of the analyst in the therapeutic process. *Psychiatry*, 1949, 12:159-166.
6. Blake, R. R., & Ramsey, G. V. (Eds.) *Perception: an approach to personality*. New York: Ronald, 1951.

7. Bordin, E. S. Ambiguity as a therapeutic variable. *J. consult. Psychol.*, 1955, 19:9-15.
8. Bordin, E. S. *Psychological counseling*. New York: Appleton-Century-Crofts, 1955.
9. Brody, N. W. Transference and countertransference in psychotherapy. *Psychoanalytic Rev.*, 1955, 42:88-94.
10. Bruner, J. S., & Goodman, Cecile G. Value and need as organizing factors in perception. *J. abnorm. soc. Psychol.*, 1947, 42:33-44.
11. Bruner, J. S., & Postman, L. Emotional selectivity in perception and reaction. *J. Personality*, 1947, 16:69-77.
12. Cohen, Mabel B. Countertransference and anxiety. *Psychiatry*, 1952, 15:231-243.
13. Estes, S. G. Concerning the therapeutic relationship in the dynamics of cure. *J. consult. Psychol.*, 1948, 12:76-81.
14. Ferenczi, S., & Rank, O. Developmental goals of psychoanalysis. *The development of psychoanalysis*. New York: Nervous and Mental Disease Publishing Co., 1925.
15. Flescher, J. On different types of countertransference. *Int. J. Group Psychother.*, 1953, 3:357-372.
16. Freud, S. *A general introduction to psychoanalysis*. New York: Liveright, 1935.
17. Freud, S. *An autobiographical study*. London: Hogarth Press, 1936.
18. Freud, S. Fragment of an analysis of a case of hysteria. In *Collected papers*. Vol. III. London: Hogarth Press, 1925.
19. Gitelson, M. The emotional position of the analyst in the psychoanalytic situation. *Int. J. Psycho-Anal.*, 1952, 33:1-10.
20. Glover, E. Symposium on the therapeutic results of psychoanalysis. *Int. J. Psycho-Anal.*, 1937, 18:125-132.
21. Greenacre, Phyllis. The role of transference. *J. Amer. psychoanalytic Ass.*, 1954, 2:671-684.
22. Heimann, Paula. On countertransference. *Int. J. Psycho-Anal.*, 1950, 31:81-84.
23. Heimann, Paula. Dynamics of transference interpretations. *Int. J. Psycho-Anal.*, 1956, 37:303-310.
24. Hoffer, W. Transference and transference neurosis. *Int. J. Psycho-Anal.*, 1956, 37:377-379.
25. Hora, T. Beyond countertransference. *Amer. J. Psychother.*, 1956, 10:18-23.
26. Horney, Karen. *New ways in psychoanalysis*. New York: Norton, 1939.
27. Ivimey, Muriel. Developments in the concept of transference. *Amer. J. Psychoanal.*, 1944, 4:122-133.

28. Kanzer, M. Past and present in transference. *J. Amer. psychoanalytic Ass.*, 1953, 1:144-154.
29. Lagache, D. Some aspects of transference. *Int. J. Psycho-Anal.*, 1953, 34:1-10.
30. Levine, R., Chein, I., & Murphy, G. The relation of intensity of a need to the amount of perceptual distortion: a preliminary report. *J. Psychol.*, 1942, 13:283-293.
31. Little, Margaret. Countertransference and the patient's response to it. *Int. J. Psycho-Anal.*, 1951, 32:32-40.
32. Macalpine, Ida. The development of the transference. *Psychoanalytic Quart.*, 1950, 19:501-539.
33. Maier, N. R. F. *Frustration: the study of behavior without a goal*. New York: McGraw-Hill, 1949.
34. Miller, N. Theory and experiment relating psychoanalytic displacement to stimulus-response generalization. *J. abnorm. soc. Psychol.*, 1948, 43:155-178.
35. Money-Kyrle, R. E. Normal countertransference and some of its deviations. *Int. J. Psycho-Anal.*, 1956, 37:360-366.
36. Mowrer, O. H. *Learning theory and personality dynamics*. New York: Ronald, 1950.
37. Nacht, S. Technical remarks on the handling of the transference neurosis. *Int. J. Psycho-Anal.*, 1957, 38:196-203.
38. Nunberg, H. Transference and reality. *Int. J. Psycho-Anal.*, 1951, 32:1-9.
39. Orr, D. W. Transference and countertransference: A historical survey. *J. Amer. psychoanalytic Ass.*, 1954, 2:621-670.
40. Paulsen, Lola. Transference and projection. *J. analytic Psychol.*, 1956, 1:203-206.
41. Postman, L., Bruner, J. S., & McGinnies, E. Personal values in perception. *J. abnorm. soc. Psychol.*, 1948, 43:142-154.
42. Proshansky, H., & Murphy, G. The effects of reward and punishment on perception. *J. Psychol.*, 1942, 13:295-305.
43. Racker, H. Contribution to the problem of countertransference. *Int. J. Psycho-Anal.*, 1953, 34:313-324.
44. Racker, H. The meaning and uses of countertransference. *Psychoanalytic Quart.*, 1957, 26:303-357.
45. Reich, Annie. On countertransference. *Int. J. Psycho-Anal.*, 1951, 32:25-31.
46. Rioch, Janet MacK. The transference phenomenon in psychoanalytic therapy. In P. Mullahy (Ed.) *A study of interpersonal relations*. New York: Hermitage, 1950.
47. Rogers, C. R. *Client-centered therapy*. Boston: Houghton Mifflin, 1951.

48. Rogers, C. R. *A theory of therapy, personality, and interpersonal relationships, as developed in the client-centered framework*. Chicago, 1956. (Mimeographed.)
49. Sanford, R. N. The effects of abstinence from food upon imaginal processes: a preliminary experiment. *J. Psychol.*, 1936, 2:129-136.
50. Sanford, R. N. The effects of abstinence from food upon imaginal processes: a further experiment. *J. Psychol.*, 1937, 3:145-159.
51. Schmideberg, Melitta. A note on transference. *Int. J. Psycho-Anal.*, 1953, 34:199-201.
52. Shafer, R., & Murphy, G. The role of autism in a visual figure-ground relationship. *J. exp. Psychol.*, 1943, 32:335-343.
53. Spitz, R. A. Transference: the analytical setting and its prototype. *Int. J. Psycho-Anal.*, 1956, 37:380-388.
54. Thompson, Clara. Transference as a therapeutic instrument. *Psychiatry*, 1945, 8:273-278. Also in A. H. Brayfield (Ed.), *Readings in modern methods of counseling*. New York: Appleton-Century-Croft, 1950.
55. Thompson, Clara. The role of the analyst's personality in therapy. *Amer. J. Psychother.*, 1956, 10:347-367.
56. Waelder, R. Introduction to the discussion on problems of transference. *Int. J. Psycho-Anal.*, 1956, 37:367-368.
57. Warkentin, J. Support through non-reassurance. *Amer. J. Psychother.*, 1956, 10:709-715.
58. Weigert, Edith. Contribution to the problem of terminating psychoanalyses. *Psychoanalytic Quart.*, 1952, 21:465-480.
59. Wolstein, B. *Transference: its meaning and function in psychoanalytic therapy*. New York: Grune & Stratton, 1954.
60. Wood, A. B. Transference in client-centered therapy and in psychoanalysis. *J. consult. Psychol.*, 1951, 15:72-75.
61. Wyatt, L. The self-experience of the psychotherapist. *J. consult. Psychol.*, 1948, 12:83-87.
62. Zetzel, Elizabeth R. Current concepts of transference. *Int. J. Psycho-Anal.*, 1956, 37:369-376.

CHAPTER 10

Diagnosis and Evaluation

The reader will no doubt have noticed, and perhaps wondered about, the fact that in our consideration of the fundamentals of psychotherapy no mention was made of diagnosis or evaluation. This omission was not accidental, nor an oversight.

Most books and discussions of counseling and psychotherapy begin with diagnosis, indicating that diagnosis or evaluation is the basis of psychotherapy. But in the client-centered point of view developed in this book, diagnosis or evaluation is not considered to be a necessary or essential condition for counseling and psychotherapy. Nor are tests considered to be useful or desirable parts of the therapeutic process. This is in contrast to vocational and educational counseling, where tests are useful in most cases.

Although evaluation and testing are not essential for psychotherapy, there are nevertheless occasions when the counselor or therapist may need to make certain evaluations, perhaps with the help of tests. It is therefore appropriate to consider the nature of diagnosis and evaluation, and to indicate their place in the functioning of a counselor or psychotherapist.

THE NATURE AND CHARACTERISTICS OF DIAGNOSIS

The concept and the term diagnosis have their origins in medicine. In medicine, diagnosis is the distinguishing of an illness or

disease, and its differentiation from other diseases. It is based on the classification of illness or disease into discrete, mutually exclusive categories, each of which is characterized by a common origin or cause, a common course, and a common prognosis or outcome. It is not necessary that the cause be known; Hippocrates was able to recognize and classify diseases without knowledge of their causes. Nevertheless, a common, specific etiology is present, which manifests itself in the common symptoms, course, and outcome. Hunt (31) defines diagnosis as "a process of scientific observation and classification whereby the clinician, through the recognition of observed similarities, is enabled to identify the behavioral picture under observation as one of a common class or type."

The concept and term have been taken from the field of physical disorders and disturbances and applied to personality or psychological disorders and disturbances. It is perhaps only natural that the transfer should be made. Hippocrates himself made the first attempt to classify personality extremes—or personality disorders—into sanguine, phlegmatic, melancholic, and debilitated types.

This transfer implies that physical and psychological disturbances are similar, i.e., that they can be differentiated into discrete groups or classes, each with a common etiology, symptomatology, course, and outcome. This assumed similarity is expressed in the use of the terms illness and disease with reference to psychological and personality disorders.

The extension of the concept, however, does not guarantee similarity. In fact, if one looks closely at the problem, the validity of the analogy between physical disease and mental disturbance may be seriously questioned. The two are quite different in many respects. The nature of the etiology is quite different. In the case of physical disease, though there are common factors of stress, there is always a specific, ultimately verifiable, physical or external agent, whether chemical, bacteriological, or viral in nature. Such a statement cannot as yet be made regarding mental disorders. In

the case of physical disease, the process is primarily one of chemical and physiological malfunctioning. In mental disturbance, on the other hand, the process is primarily a psychosocial disturbance. In physical disease, patients having the same disorder follow rather closely the same course, with the same predictable outcome in most cases. In mental disturbances, on the other hand, there are wide differences in the course and outcome among those classified as having the same diagnosis. This disconcerting fact has caused considerable difficulty to those (such as Kraepelin and Bleuler) attempting to establish classification systems. Finally, for physical diseases there exist either known, or as yet unknown, specific remedies. Again, though the search and hope for such specific remedies continue, none has been found for the presumed different personality disturbances.

The differences between physical and mental or emotional disorders raise a serious question as to whether the use of the same terms, such as illness, disease, and sickness, should be applied to both. As Combs (13) points out, these are prejudiced words, and their use in psychology produces misunderstanding and confusion. Psychiatrists, however, are strongly attached to the use of these words, both because they desire to identify with medicine and the medical profession, and because they desire to retain the legal monopoly on the treatment of emotional disturbances. Some, however—Szasz (75), for example—have raised the question as to whether mental disorder is actually a disease.

Dissatisfaction with classification systems for personality disturbances has been widespread, among both psychologists and psychiatrists. To be useful, a system of classification must possess certain characteristics, some of which Bordin (5) has pointed out. A basic requirement is that the system result in reliable classification of subjects among its categories. Different classifiers should agree in the assignment of subjects. No psychological or psychiatric classification system yet devised meets this requirement. Psychiatric diagnosis is notoriously unreliable (1, 16, 46). A recent

study (68) reports considerable agreement in assigning patients to broad categories, such as organic psychosis or character disorder. But in some cases there is considerable disagreement in classifying patients as psychotic or neurotic. Hunt *et al.* (33, p. 51) report only 54 percent agreement on classifying patients as psychotic, neurotic, or personality disorder, and only 32.6 percent agreement on more specific diagnoses. It is common for patients to receive several different diagnoses when moving from hospital to hospital, and indeed, even during their stay in a single hospital.

The characteristic which makes reliability in classification possible, within errors of observation, etc., is the mutual exclusiveness of the categories. The categories must not overlap. In practice, definitions of classes of psychiatric disorders are not mutually exclusive. Classifications are based primarily on symptoms, except in the case of organic mental disorders, since causes are unknown. Some feel that this situation can be remedied as causes are discovered. But if there were discrete classes of disorders, they should be identifiable by constant, discrete symptom clusters, as Jenkins (34) suggests.

Several factor analyses of psychiatric symptoms have been made. Wittenborn (81) found seven factors in intercorrelations of symptom rating scales, which bear some relationship to the commonly used psychiatric categories. Repeating the study on patients in another hospital he found similar results (84).

Lorr and his colleagues have conducted similar studies. In a study of mental hospital patients (40), 11 factors were found, some of them similar to those found by Wittenborn, and three second order factors were identified. Ten first order and two second order factors were obtained in a study of psychiatric outpatients (42). In a later study, (which included some of Wittenborn's scales) of patients from eight hospitals (41), nine first order and two second order factors were found, which showed considerable agreement with the earlier study of hospital patients and with Wittenborn and Holzberg's study.

Before too much weight is placed upon the apparent agreement between the factors and psychiatric classifications, Wittenborn's caution should be considered. He writes: "If psychiatrists believe consistently that certain symptoms go together, the ratings which they make for their patients may reveal their belief concerning symptom-clustering. Accordingly, if syndromes are revealed among the symptoms, the possibility remains that the syndromes are more descriptive of consistencies which exist in the behavior of psychiatrists than they are descriptive of consistencies which exist in the behavior of patients" (81).

In another study of outpatients (66), nine categories evolved from an obverse factor analysis. In this study, there was no relationship between the categories and standard psychiatric diagnoses. In a study of a group of hospitalized patients with schizophrenic diagnoses, Guertin (25) found six factors which were not identifiable as the common subtypes of schizophrenia. However, an obverse analysis of 20 schizophrenics resulted in three factors similar to the hebephrenic, paranoid, and simple types (26). But seven patients showed a mixture of two, and one of three, factors. No general factor appeared. In an analysis of ratings on the Hospital Adjustment Scale Guertin found one large and two smaller group factors, highly intercorrelated (28). However, the homogeneity of the items and possible halo effect in ratings by psychiatric aids may have influenced these results. In another study using an Activity Rating Scale five types of schizophrenics were isolated, with little correlation between the factors (29).

Wittenborn (82, 83, 86) studied groups of 20 patients diagnosed as involutional melancholia, organic psychosis, and manic-depressive (manic state). He found that the groups were not homogeneous, six factors being isolated in each group.

The results of these and other factor analytic studies may be taken to support, to some extent, the present diagnostic system. However, Wittenborn's caution indicates that the agreement may be an artifact. When groups having the same diagnosis are

studied, they do not appear to be homogeneous. Wittenborn, Holzberg, and Simon (85) found that although there were differences in symptom clustering among major diagnostic groups, there was also considerable overlap in symptoms among the groups. Moreover, it must be remembered that all these studies involve the use of ratings, not personality tests or measures. Little work has been done with tests designed specifically to isolate factors or types of abnormal behavior or individuals. Guertin (27), using the Bender-Gestalt, found five types of schizophrenics bearing some resemblance to three of the common subtypes of schizophrenia. Monroe (48), using a Q-technique (similar to self-ratings), found 20 different groups, some similar to psychiatric classifications; but 50 of the 200 patients studied could not be placed in any one of the groups.

Whether using factors as a basis for classification would result in increased reliability has not been demonstrated. And whether such "purified" symptom categories would be more useful, or better meet other criteria for a classification system is, of course, unknown. A requirement of any useful classification system is that the basis of classification be of some practical significance. It is possible that a symptom classification, if not related to differing underlying causes, may be of little value even if reliable.

Related to the characteristic of mutual exclusiveness of categories or the degree of overlap is the homogeneity of subjects within categories, and the heterogeneity of subjects among categories. In statistical terms, to be useful, a classification system must result in greater variance among categories than within categories. It appears that present systems do not meet this requirement well; patients with the same diagnosis vary almost as much as patients with different diagnoses. This suggests that the basis of classification, i.e., mainly symptoms, is not a particularly relevant variable. A useful system of classification must allow for significant differential predictions about individuals in different categories. This is the prognosis factor in illness. There is little evidence that

present classification systems for mental disturbances enable one to make such predictions.

Finally, a system which makes significant groupings of subjects would point to differences in the treatment of subjects in different groups. As Bordin (5) states it, "From the theoretical as well as from the applied point of view, the most vital characteristic of a set of diagnostic classifications is that they form the basis for the choice of treatment." Thorne says that ". . . rational therapy depends upon valid diagnosis, which depends upon an exact knowledge of the etiology and dynamic nature of morbid processes" (78, p. 8). He recognizes, however, that "most of the current theories of aetiology, diagnosis, therapy and prognosis have not been statistically validated" (78, p. 13). Now there are those who claim that present diagnostic categories do point to differential treatment. Thorne (78) attempts to specify these differences. But he presents no experimental evidence to support differential treatment. Nor is there agreement among those who take this point of view as to the appropriate treatment for specific diagnostic groups. In practice, psychiatric diagnosis has little influence upon methods of psychotherapy. Parloff, Kelman, and Frank (51) write that ". . . the unpleasant truth is that there is no agreement as to what kind of psychotherapy is best for different patients or psychiatric disorders . . . at present the type of treatment received by a patient is largely determined by the accident of training of the therapist to whom he happens to go."

In practice then, methods of therapy depend more upon the training, experience, and preferences of the therapist than upon the diagnosis. Those who feel that psychotherapy should be selective and specific, and thus rational, chosen on the basis of diagnosis, have been unable to relate specific therapies to specific diagnoses, in terms of indications and contraindications, except possibly on the basis of severity of the condition. Thus, psychotherapy may not be possible in severely disturbed, mute, or non-verbal psychotics. Among those accessible to psychotherapy, there

is only opinion rather than evidence, regarding differential techniques of psychotherapy. Attempts to list indications or contraindications are more often in terms of symptomatic versus basic treatment, or the depth of therapy desired or possible, the time available, etc. In other words, the distinctions are based upon the limits of the therapist and the therapeutic situation rather than being related to the diagnosis or etiology of the disorder.

In spite of the admitted inadequacies of all known diagnostic classification systems, there is great reluctance to abandon the attempt to develop an adequate system. Zilboorg, in *A History of Medical Psychology*, writes that "To give a comprehensive nosology, to classify carefully, to produce a well-ordered classification almost seems to have become the unspoken ambition of every psychiatrist of industry and promise, as it is the ambition of a good tenor to strike a high C. This classificatory ambition was so conspicuous that the composer Berlioz was prompted to remark that after their studies have been completed a rhetorician writes a tragedy and a psychiatrist a classification" (89, p. 451).

There is strong motivation toward this goal, since it appeals to the need of man to simplify, to classify, to reduce data. Indeed, it is commonly accepted that "'naming,' nosology, or classification, is the basis of all science, indeed of all human knowledge. Without classification, knowledge would remain sterile. It could not be increased" (73, p. 352). Recognizing the imperfect nature of current systems of classification, Hunt (31) states that "nevertheless they represent the best means of prediction at hand and their use, contemporary with their correction and development, is the only alternative to scientific chaos."

Another reason for the desire for a diagnostic system is to have some method of controlling cases in comparisons of different treatments. "There can be no completely definitive demonstration of the differential validity of treatment without knowledge of what we are treating" (5).

Much as it is needed, an adequate diagnostic system has not yet

been devised, despite the efforts of hundreds of competent people over a period of centuries. There is actually little agreement upon definitions of various nosological categories, even the broad classes designated as psychoses and psychoneuroses. "To separate [mental] disorders into two groups, neuroses versus psychoses, is one of the most popular dichotomies. But it is too simple and just will not fit the facts. In fact, even the definitions given of neurosis and psychosis are not clear, and usually no definitions are given" (12, p. 18). Redlich writes: "As a psychiatrist, I should be able to give a definition of the term 'psychosis,' one of the major terms in our field; however, in agreement with Bowman, I feel it is impossible to differentiate psychosis from other terms such as neurosis, based on their etiology, clinical description, or prognosis. It is equally difficult to establish a clear distinction between psychosis and psychoneurosis based on the psychodynamic considerations of Sigmund Freud, Franz Alexander, L. S. Kubie, and others who dealt with this problem" (55, p. 68).

The failure of psychiatric diagnostic systems to meet the requirements of a useful classification system brings into question the appropriateness of the analogy between physical and mental disorders. The assumption is that mental disorders, like physical disorders, are separable into discrete entities. An alternate assumption, consistent with the failure to find such discrete entities, is that all mental and emotional disorders are basically similar in nature. This was suggested in the discussion of the nature of emotional disturbances in Chapter 7. As indicated there, this is not a new idea (12, 55, 72). It no doubt has origins in antiquity, and has perhaps been suggested cyclically in the history of psychiatry. Stainbrook (71, p. 12) cites Bayle as attempting to reduce all psychopathology to manifestations of one pathological process in 1822. Zilboorg quotes Heinrich Neuman (1814-1884) as saying, "We shall never be able to believe that psychiatry will make a step forward until we decide to throw overboard the whole business of

classifications. . . . There is but one type of mental disturbance and we call it insanity" (89, p. 438).¹

The common element in mental and emotional disorders which we have proposed is stress resulting from threat to the preservation and enhancement of the self. This common etiology may appear to conflict with the concept, or doctrine, of multiplicity of causes of behavior. Actually, however, it does not necessarily do so. There are various types of stress, and varying reactions to stress which are influenced by hereditary, constitutional, and experiential factors. These differences account for the variety of reactions and symptoms in emotional disturbances. Some of these differences may be of significance, and thus of diagnostic importance. But so far, at least, none has been demonstrated to be so.

DIAGNOSIS AS UNDERSTANDING

The foregoing discussion of diagnosis will not dispose of the problem for those who are familiar with the use of the term in the counseling literature. Diagnosis has been extended beyond classification. It has come to be associated with a detailed description of the individual (5, 6, 67, 78, 80). Williamson defines diagnosis in several ways; one definition states that diagnosis is "a terse summary of problems, their causes, and other significant and relevant characteristics of the student, together with the implications for potential adjustments and maladjustments" (80, p. 178). Again, he says: "The art of clinical diagnosing is defined as the evaluation and interpretation of the meaning and prognostic significance of data" (80, pp. 207-208). Thorne's definition is similar: "Diagnosis refers to the description of the organism and its behavior by a variety of methods whose basic purpose is to discover the personality dynamics of each individual case" (78, p. 4). He lists ten objectives of diagnosis, which include the demonstration of etiological factors, the nature and extent of the morbid process,

¹ An interesting statement of this position appearing after the above was written may be found in K. Menninger, H. Ellenberger, P. Pruyser, and M. Mayman. The unitary concept of mental illness. *Bull. Menninger Clin.*, 1958, 22:4-12.

the determination of prognosis and probable course, and the formulating of a dynamic hypothesis of the process as a rational basis for specific psychotherapy.

The extension of diagnosis beyond nosological classification becomes a case analysis and evaluation. The purpose of such description and analysis is expressed as the development of understanding of the client. When diagnosis is attacked as being unreliable and useless for therapy, those who use diagnosis in this broad—and nonspecific—meaning ask if it is not desirable and necessary to understand the client in order to engage in psychotherapy.

Not only is this an unjustifiable use of the concept of diagnosis, but more important, it represents a failure to distinguish two types of understanding—or to distinguish understanding of from knowledge about a client. This distinction was dealt with in Chapter 8. Diagnostic knowledge, or understanding, is understanding from an external point of view. It is knowledge about the client, rather than knowing him. It always has an evaluative element, which is detrimental to client-centered therapy. For this reason, such knowledge, even though it goes beyond classifying, is not desirable in psychotherapy if one accepts the point of view adopted in this book.

It might be pointed out here also that, if such knowledge were desirable, we are unable to achieve it at the present time. Elkin's study (16) illustrates the disagreement among experts in such diagnostic descriptions. Clinical evaluations are notoriously ambiguous and unreliable; the literature supporting this statement is too voluminous to review or even cite in detail (e.g., 14, 15, 24, 32, 43, 57). There is perhaps some current justification for the criticism of Neuman, reported by Zilboorg (89, p. 438), about the descriptions of patients in which each trend is recorded in the light of the observer's personal predilections. These, he said, are not histories but novels.

Zilboorg has noted: "It would appear justifiable to state that

with rare exceptions the tendency to develop classifications grew in inverse proportion to the psychiatrist's clinical interest in the patient as an individual" (89, p. 422). Perhaps this might be applicable to therapists today. It is interesting that those persons who are most closely engaged in psychotherapy appear to be least concerned about diagnosis. As a group, for example, psychoanalysts give less attention to diagnosis than other psychiatrists. A classification system, while ostensibly designed to aid in the understanding of the individual, is in danger of causing the therapist to fail to see the unique individual behind the classification. This is particularly true where there is so much variability within any classification. Rogers (60) has suggested (in a footnote) that if the possession of diagnostic knowledge is necessary to give the therapist a feeling of security, he "might be made equally comfortable by being given the diagnosis of some other individual, not of this patient or client. The fact that the diagnosis proved inaccurate as psychotherapy continued would not be particularly disturbing, because one always expects to find inaccuracies in the diagnosis as one works with the individual."

While this might give the therapist some feeling of security, and thus improve his functioning as a therapist, he still would be functioning from an external frame of reference. The client-centered point of view not only states that diagnostic knowledge is not a necessary condition of psychotherapy, but that such knowledge is undesirable, even if it were to be reliable and valid. A quotation from Zilboorg sums up the client-centered position quite well: "It matters very little whether or not you understand what you call the Oedipus complex, but it matters a great deal whether you understand your patient" (90, p. 108).

TESTS IN PSYCHOTHERAPY

The use of tests has been advocated in psychotherapy for various purposes. First, of course, they have been used as diagnostic instruments, though there is actually very little, if any, real evi

dence that tests are useful in predicting a clinical psychiatric diagnosis, except possibly in organicity.

Thorne, among others, suggests that tests may be a useful introduction to therapy, though there is no evidence that they are. He writes: "If handled tactfully, psychological testing may facilitate counseling markedly" (78, pp. 40-41). Some feel that testing prior to therapy leads to clients failing to continue contacts (6, p. 185), though the only study dealing with this problem (44) did not find any evidence for this. Kirk and Headley (35), however, in a study of vocational counseling found that 32 percent of those discontinuing counseling did so during the testing process. Their analysis of factors in discontinuance included only reasons apparent from the counseling records or counselor's impressions, so that testing does not appear as a factor in their study, though there is certainly a suggestion in the data that this might have been a reason. That testing prior to counseling may have deleterious effects is, however, recognized by Thorne. He feels that "many of the potentially inhibiting effects of testing upon counseling may be eliminated if the testing has been completed by separate personnel either shortly before or after the first counseling interview. Usually the testing procedure is relatively painless, and even if undesirable reactions are encountered, the fact of separate personnel tends to dissociate such undesirable effects from the counselor" (78, p. 40).

Tests have also been suggested as a means of reality-testing by the client (6, p. 266). Rogers (58, 59) has indicated that, when requested by the client late in the counseling process, tests may help the client gain an objective picture of himself, his interests, aptitudes, and abilities. However, both Bordin and Rogers are here thinking of educational and vocational counseling rather than psychotherapy. Some counselors and therapists advocate the same approach regarding the use of personality tests in psychotherapy. Although there may be instances where this procedure is useful or

desirable, this writer has very rarely had clients ask to take personality tests.

Even when personality tests are requested there are some reservations about using them in this manner. In the first place, the results of such tests are likely to be more threatening to the client than are tests of interests and aptitudes. Therapy may be slowed or disrupted by interpretation and discussion of the results. Test results by themselves will not necessarily enlighten the client. It is usually better, or necessary, that he work things through for himself. Second, the reliabilities, and particularly the validities, of personality tests are so unsatisfactory, compared to tests of interests and aptitudes, that little confidence can be placed in them in individual cases. It seems to be better for the client's therapy to deal with his personality characteristics without the use of tests.

Tests have sometimes been suggested as a means of facilitating the productions of the client in therapy (53). It would appear that this might be useful with clients who, while recognizing the need for therapy, are unable to verbalize or produce any thoughts regarding their problems. It has been the experience of the writer, however, that with these difficult clients, using such tests as the TAT to attempt to stimulate thinking and verbalizing has not been successful. In those cases where clients do respond to such a technique, it is not necessary.

Perhaps the most frequently suggested use of tests has been to assist the counselor in understanding the client (7). Here we meet the same problem which we dealt with in our discussion of diagnosis. Tests provide information from an external point of view, rather than providing an understanding of the client from an internal, or phenomenological, frame of reference. This statement may not be entirely true, however. Snygg and Combs (70, pp. 258 ff.) point out some of the types of test items which can reveal the client's frame of reference. McArthur (19) has argued that projective, or unstructured tests provide a method of understanding the individual rather than placing him in a diagnostic category. While

this may be so, we actually do not as yet know the meanings of individual responses to projective techniques. Moreover, the introduction of such approaches into psychotherapy may be unnecessary, and have undesirable consequences to the therapeutic relationship. One may look at the client-centered interview as being a projective or unstructured situation itself, and perhaps one which elicits less ambiguous responses than do the projective tests. The superiority of the therapeutic interview for obtaining an understanding of the individual personality has not been challenged by our available tests. As Wyatt (88) points out, a grasp of the complex factors of personality "so far can only be achieved in the extensive continuity of psychotherapy, from which the variables searched for in projective testing were, in fact, originally derived."

In view of the lack of evidence for the usefulness of tests in psychotherapy, one wonders why they are so extensively used. Rogers writes: "When one thinks of the vast proportion of time spent in any psychological, psychiatric, or mental hygiene center on the exhaustive psychological evaluation of the client or patient, it seems as though this *must* serve a useful purpose in so far as psychotherapy is concerned. . . . It may be that its defense as a necessary prelude to psychotherapy is simply a protective alternative to the admission that it is a colossal waste of time" (60). Meehl states that "If all the thousands of clinical hours currently being expended in concocting clever and flowery personality sketches from test data could be devoted instead to scientific investigation it would probably mean a marked improvement in our net social contribution" (45). If this time were devoted to psychotherapy, we would have less of a problem with the need for therapy being so much greater than the resources available. Meehl² justifies the effort in terms of the necessity for developing accurate descriptions of personality if we are ever to test whether such descriptions are therapeutically helpful. But perhaps the most

² Personal communication.

important reason (recognized by Meehl³) why so many clinical psychologists spend so much time in routine diagnostic activity is that it is expected and required of them by psychiatrists.

THE PLACE OF EVALUATION

Diagnosing and testing involve evaluation on the part of the counselor. Evaluation has no place in client-centered therapy. In this respect client-centered therapy differs from some other types of therapy, which attempt to combine an evaluative—or objective—frame of reference with the understanding—or subjective—frame of reference.

Evaluation is not desirable in therapy because of its interference with empathic understanding, and its threat to the client. There are perhaps some who might agree that it is undesirable, but who feel that it is necessary, that the counselor cannot avoid evaluation. Evaluation is necessary when the counselor must make a decision. In client-centered therapy the counselor, as therapist, does not engage in decision making. Now there are times when the counselor must make decisions about the client, and must therefore evaluate. But, when he is engaged in this process of evaluation and decision making, he is not acting as a therapist.

There are situations where the therapist may be faced with the necessity of making a decision. Perhaps the most common, and most important, is the acceptance, or selection, of clients. The therapist must decide in the first two or three interviews whether he is competent to work with a particular client. Hunt (31) states that an important function of diagnosis is to enable the therapist "to recognize conditions which he is not equipped to treat, and to call, by the process of referral, upon necessary medical assistance." Chapter 3 referred to the responsibility of the counselor to avoid offering services or attempting to perform functions beyond his level of training or competence. Each therapist must make this decision for each client. There are no easy rules to apply here. The

³ Personal communication.

kinds of clients a therapist accepts depend upon his own particular background of training, experience, and confidence and ease of working with particular clients. As indicated in Chapter 7, the client-centered approach is not dangerous, even when used by a relatively inexperienced counselor with a seriously disturbed client. Nevertheless, if the therapist is insecure, anxious, and feels inadequate, progress is not likely to occur. There is also the problem of the presence of organic disease, whether it is the cause of or concomitant with personality disturbances. This is the rallying point for those who feel that psychotherapy should be engaged in only by those having medical training. The writer knows of no experimental evidence that nonmedical therapists are more prone to mistake organic disease for functional personality disorders than are medically trained therapists. Personal experience suggests the opposite. Certainly the nonmedically trained therapists known to the writer are extremely careful about this problem.

These decisions usually must be made early in the counseling process, though sometimes as the process continues problems may arise which require the counselor to reevaluate the situation. Organic symptoms may develop during the course of therapy. The client's condition may appear to become more serious, so the therapist may consider hospitalization. The development of new complaints or symptoms, or the apparent increase in seriousness of the client's condition may raise the question of referral for other services, or to a more experienced therapist.

These problems raise the question of the usefulness of tests in making decisions. The position taken here is similar to that taken above on the use of tests to help the client evaluate himself. The demonstrated validities of personality tests are so unsatisfactory that they do not seem to be worth the potential damage to the therapeutic process by the open introduction of evaluation. One exception, perhaps, is the case where organic brain disease is suspected. Here, psychological tests, as well as the EEG and other diagnostic procedures, may be helpful. But these cases can best be

handled in the same way as other cases involving known or suspected organic disorders—by referral for evaluation to a competent clinical psychologist, neurologist, or other medical specialist.

There is another aspect of the selection of clients. Therapists desire to devote their efforts to clients who are likely to be able to benefit from therapy. Particularly where there is a greater demand for than a supply of therapeutic service, selection of clients on this basis may be desirable. Psychoanalysts commonly select patients on the basis of several trial interviews. This is perhaps the most common practice of other therapists also, though in most cases perhaps the clients make the selection or decision, by not continuing in therapy.

If clients are to be selected in terms of likelihood of successful results, then we must have some basis on which to estimate this likelihood. Several studies have been concerned with this problem.

One of the requirements of successful therapy is that the client remain in therapy for a length of time sufficient for improvement or benefit to occur. Therefore, studies of factors related to persistence in psychotherapy might offer some suggestions for the selection of clients. Chapter 5 has already referred to some studies relevant to this problem. There it was suggested that persistence in therapy is related to social class level, with clients from the lower classes being less accepting of therapy and tending to continue in therapy for shorter periods of time. Gibby *et al.* (22) also report some support for this conclusion. Sullivan *et al.* (74) found continuers to be superior in education and occupation, but Gibby *et al.* found no difference in education. Rubinstein and Lorr (65) also found remainers to be more intelligent, better educated, and at a higher occupational level than terminators. Auld and Eron (2) found continuers more intelligent, and middle class or upwardly mobile lower class.

Auld and Myers write: "On his decision to accept or reject a patient [the therapist] is quite often influenced by the results of psychological tests. There is no general agreement, however, on

what test results ought to persuade the therapist to accept a patient, and what results ought to induce him to reject a patient" (3). A review of studies in this area lends support to this statement.

Several studies relate test factors to continuation in psychotherapy. Rogers, Knauss, and Hammond (63) found that three psychologists were unable to predict from the Rorschach protocol in a "total impression" manner which patients would continue in therapy, though they agreed in the selection of criteria used in making their judgments. In addition, 99 objective scores from the Rorschach failed to differentiate the continuers from the non-continuers. Kotkov and Meadow (38), however, found that two Rorschach scores which had discriminated between continuing and noncontinuing group psychotherapy patients also did so for groups of patients in individual therapy. These scores were FC minus CF, and R. But when Auld and Eron (2) applied the discriminant formula to another sample of patients, it failed to discriminate between those who continued and those who did not continue in therapy. R alone did show some discrimination, but when IQ was partialled out of the relationship, it dropped to insignificance; the correlation between IQ and continuance was .71. Gallagher (20) found that those who discontinued therapy tended to be less productive, as well as less anxious (Taylor Manifest Anxiety Scale) than those who continued.

A study by Gibby *et al.* (23) of two extreme groups (less than five and 20 or more sessions) found a number of Rorschach scores to be discriminating, though many of them were related to R. In a further study (22), these investigators developed a formula which included R, K, and M responses which discriminated in another sample between patients who remained in therapy less than 20 sessions and 20 or more sessions. Since K correlated — .60 with R, R alone was tried, and was successful in discriminating terminators and nonterminators. However, the prediction was not very greatly superior to chance. In this study IQ did not discrimi-

nate as well as in the Auld and Eron study, and R was not as closely related to IQ. Auld and Eron found in their samples, and also determined it to be true of other studies cited above, that terminators are more accurately identified than nonterminators. They point out factors in the nature of the samples and of therapists and type of therapy which probably affect continuation in treatment.

Taulbee (76) found continuers to be higher on the D, Hy, Mf, Pa, Pt and Sc scales of the MMPI, than those who discontinued prior to the thirteenth interview. He also found that the continuers gave more C, Y, V, S, and An responses on the Rorschach, as well as more total responses, rejected fewer cards, and had a higher A%. Taulbee developed an empirical prognostic scale from both tests. However, it was not cross-validated. Gibby *et al.* (23) found that several of the special MMPI scales (including Gough's Intellectual Efficiency Scale) discriminated between stay and nonstay groups. Of the standard MMPI scales, only K and Pa differentiated the groups, with the stay group being higher on K and lower on Pa. These results were not supported in two other, somewhat smaller, samples and when all three samples were combined, only education and occupation discriminated between the groups.

Rubinstein and Lorr (65), using two extreme groups (five or less visits and six months or more of treatment) found differences in several measures (including 25 items from the F scale, self and self-ideal ratings, a vocabulary test, and several socio-economic items). Remainders were less nomadic, less impulsive, less rigid in personal attitudes, but more self-dissatisfied.⁴

In addition to studies attempting to predict continuation in therapy, there have been several studies attempting to predict progress or success in psychotherapy. One of the earliest studies was that of Harris and Christiansen (30) using the Rorschach,

⁴ Similar results were obtained in a study reported after the above was written: M. Lorr, M. M. Katz, & E. A. Rubinstein. Prediction of length of stay in psychotherapy. *J. consult. Psychol.*, 1958, 22:321-327.

MMPI, and a short, there may have been differences in the criteria was rating of suitability, residents, or differences in the selection of patients and the psychiatric studies by these authors indicated that upper-class. Though the cases referred to staff psychiatrists, and such patients, as difference was not a better prognosis. Auld and Myers do not higher on the MMPI selection occurred in the study referred to. between upper and lower improvement is positively related to duration for any of the Rorschach and Myers (3) report that 79 percent of Rorschachs in "good" and in interviews either quit or were dislevel); however, he had available to 15 percent of those seen for the (nonsignificant) differences 7) also found a positive relation

Rogers and Hammond (62) used success. Cartwright (9) found a discriminate between 50 unimproved and 21 interan outpatient clinic. Three psychologists vs. successful cases than nate the Rorschachs of the two groups better tests that there may they agreed better than chance among themselves onal problems cations of Rorschachs. Application of the weighting system person-by Harris and Christiansen did not discriminate the groups. 1) to patterns of four scores each did not differentiate. An empirical comparison of 99 scores or signs in the two groups disclosed no significant differences. There seemed to be some prognostic value in M scores, but hardly enough to be clinically useful.

Roberts (56) compared ten Rorschach scores, suggested in the literature as having prognostic significance, in the upper and lower halves of a group of patients differing in degree of response to psychotherapy. None of the scores significantly differentiated the groups.

Barron (4) found that experienced Rorschach interpreters were unable to predict outcome of therapy on the basis of the Rorschach evaluation. The Harris-Christiansen index was not related to outcome, nor did the improved and unimproved groups differ significantly on any Rorschach determinant. Barron did find a significant positive relationship between improvement and intelligence. There was also a significant relationship between improve-

nate as well as in the Auld and Eron study, and Ron also used the related to IQ. Auld and Eron found in their study and unimproved determined it to be true of other studies cited above that the MMPI factors are more accurately identified than not correct on the average point out factors in the nature of the sampled 68 MMPI items, and type of therapy which probably affect which differentiated them.

Taulbee (76) found continuers to be high intelligence in all samples, Pa, Pt and Sc scales of the MMPI, than MMPI.

prior to the thirteenth interview. He had most successful and the 15 gave more C, Y, V, S, and An response 76 on various measures. The as more total responses, reject outcome of the measures. The least A%. Taulbee developed and as measured by the Taylor Manifest tests. However, it was not on the Elizur Rorschach anxiety scale), that several of the Mooney Problem Check List in summarizing Intellectual Efficiency were higher on the MMPI D scale. They did groups. on the Barron Ego Strength scale, however, nor on entire on R. These results are not consistent with those found by the studies mentioned above.

Sullivan *et al.* (74) also used the MMPI, finding that an unimproved group was higher than an improved group on all clinical scales except Mf and Pa. They did not differ on the Ego Strength scale, however, nor on the Gough Intellectual Efficiency or Social Status scales. There was no difference in education, but the improved were higher on occupational status.

Rosenberg (64) compared 20 improved and 20 unimproved patients selected by their therapists from approximately 400 cases, split into two groups. In the first group (10 improved and 10 unimproved) the improved clients were higher in intelligence (Wechsler-Bellevue), and were rated higher in productivity, emotional depth, sensitivity, and energy level, and lower in rigidity, stereotypy, and concern for health on the basis of the Rorschach. Fifteen other Rorschach ratings did not differentiate the groups. Two judges were informed of these results and asked to sort the

other 20 cases. On it, there may have been differences in the criteria cases, a result signi residents, or differences in the selection of pa-

In view of the adies by these authors indicated that upper-class of the Rorschach Fined to staff psychiatrists, and such patients, as psychotherapy desee a better prognosis. Auld and Myers do not authors (37) to pis selection occurred in the study referred to. client's ego-strength, that improvement is positively related to dura- on the M, FM, m, shl and Myers (3) report that 79 percent of Mindess (47) found an ten interviews either quit or were dis- sum of the six scores and npared to 15 percent of those seen for months of psychotherapy for 477) also found a positive relation half court referred cases. Omit success. Cartwright (9) found a whom prognosis was easy without usuing for from 13 to 21 inter- was .66. Kirkner *et al.* (36) found a cing successful cases than the PRS score and classification as improve ggests that there may 40 patients in a VA hospital. However, only thieational problems ing scores contributed to the prediction. Cartwright' eper person- a correlation of .52, significant at the .03 level, for enough to centered therapy cases. In this study, the M, color, and form . scores appeared to be responsible for the relationship. to

The question may be raised why these results occur where the same scores used individually do not predict. Of course, the disagreement, except for M, between two of the studies in the variables which contribute to the relationship poses a question, though this may reflect a difference between hospitalized and outpatient clients. The use of nonlinear weighting of some of the variables may be a significant factor. The PRS deserves to be checked in other studies.

An element in these results which appears to be present in other positive results also is that those who are better adjusted at the beginning of therapy are rated as better adjusted or successful following therapy. Unless improvement, rather than status following therapy, is used as a criterion, the results are not relevant to predicting response to psychotherapy. As Cartwright (10) points

nate as well as in the Auld and Eron study, and R₁ the person at the related to IQ. Auld and Eron found in their β_1 a measure of his determined it to be true of other studies cited above. Independent variable for tors are more accurately identified than none. Most studies which point out factors in the nature of the sample, actually only cor- and type of therapy which probably affect c' the end of therapy. ment.

Taulbee (76) found continuers to be high on Pa, Pt and Sc scales of the MMPI, than on the M. Similar prior to the thirteenth interview. He also hospitalized patients (17, gave more C, Y, V, S, and An responses. They are, even as more total responses, reject. They tried to make sense out of their A%. Taulbee developed a test to earlier findings. There are, of tests. However, it was not for the disagreements. Many studies that several of the studies of cases. There are differences in samples, Intellectual Efficiency, severity of problems, age, intelligence, social groups. Lack of homogeneity within samples. These factors are not controlled or studied in most investigations. In addition, the study of therapy is related to other factors than characteristics

the clients. Situational and environmental factors enter, and these were not controlled or studied. Then there are therapist variables related to outcome, including type of therapy, which have not been adequately studied. Sullivan *et al.* (74), in their study did not find the sex, professional training, or experience of the therapist significantly related to continuance in therapy. Cartwright (9) did not find the sex of the therapist related to outcome, though Seeman (69) in an earlier study found such a relationship. Myers and Auld (50) did find that outcome was related to experience of the therapist. Of those patients treated by staff psychiatrists for over ten interviews, none left treatment without the approval of the therapist, while 29 percent of those treated by residents did. The numbers discharged as unimproved did not differ between staff and residents, but proportionately twice as many were discharged as improved by staff psychiatrists. As Myers

and Auld point out, there may have been differences in the criteria used by staff and residents, or differences in the selection of patients. Previous studies by these authors indicated that upper-class patients were assigned to staff psychiatrists, and such patients, as we have seen, have a better prognosis. Auld and Myers do not indicate whether this selection occurred in the study referred to.

There is evidence that improvement is positively related to duration of therapy. Auld and Myers (3) report that 79 percent of those seen for less than ten interviews either quit or were discharged as unimproved, compared to 15 percent of those seen for 20 or more sessions. Taylor (77) also found a positive relation between duration of therapy and success. Cartwright (9) found a "failure zone," in which those continuing for from 13 to 21 interviews were less frequently rated as being successful cases than those with fewer or more interviews. He suggests that there may be two groups of clients, those with minor or situational problems who improve in a few interviews, and those with deeper personality problems, some of whom would not continue long enough to show improvement.

It seems apparent that it is not possible to predict, prior to treatment, clients who will or will not improve in psychotherapy. There is a trend for those who are more intelligent and of higher socio-economic status to continue therapy and to be rated as more successful. Other than this, the only other apparent tendency is for those who are better adjusted to begin with to be rated as more successful.

On the basis of present information, it would appear to be unjustifiable to reject any applicant for therapy on the basis of pretherapy information. The best criterion of success is continuance, and continuance can best be determined on a trial basis. Most of those who quit treatment do so rather early in the process, often before ten interviews, probably before 20. Possibly this trial period is no more expensive than the administration, scoring, analysis, and interpretation of a battery of tests.

TESTS IN EVALUATING RESULTS OF PSYCHOTHERAPY

Finally, tests are used frequently in research on the evaluation of the results of psychotherapy. The use of judgments or ratings of improvement or success is considered by many to be an unsatisfactory criterion. Tests have therefore been used as criteria, either for the purpose of measuring change during therapy, or evaluating terminal adjustment. The reported studies using evaluating tests are too numerous to review here. Perhaps the client-centered therapists have done as much in this area as any group, beginning with Muench's study (49). The results of this study, which found that changes in the Rorschach accompanied improvement in psychotherapy, have not been confirmed by other studies, such as the one by Carr (8). In general, however, the results of studies using other tests have indicated that tests have been found to be related to ratings of success (61). It is curious that tests have been accepted as criteria without adequate evidence of their validity. It will be remembered that the early, and even later, intelligence tests were validated against ratings. It might be maintained that ratings of behavior by the client, the therapist, and others, constitute the most valid criteria obtainable. There is a real question as to whether the tests or psychotherapy were being evaluated in many studies.

The use of tests to measure and control pretherapy status or adjustment has been limited. This again is an area which cannot be gone into here. It was suggested earlier that current diagnostic classifications are inadequate, because of the great heterogeneity within any diagnostic category as well as the unreliability of diagnosis. Even Thorne seems to recognize its inadequacy when he proposes a Prognostic Index (79) scale for use in equating treatment groups. The rating scales developed and used by Wittenborn and Lorr in their studies referred to above would be useful for this purpose.

This chapter has discussed the place of diagnosis and evaluation in client-centered psychotherapy. We may conclude with a state-

ment similar to those made earlier in relation to transference and other characteristics of psychotherapy: If therapeutic personality change occurs without diagnostic and evaluative activity on the part of the therapist, either prior to or during the psychotherapeutic process—and it apparently does—then diagnosis and evaluation are not necessary conditions for psychotherapy. From the client-centered point of view diagnosis and evaluation are undesirable during psychotherapy. Since it is assumed that all emotionally disturbed individuals are characterized by basically similar psychological pathology and needs, the same basic approach is suitable. This is not to say that specific techniques may not vary, for example, in terms of the severity of the disturbance and the ability of the client to verbalize.

Where evaluation is desirable, as in the selection of clients, tests apparently are able to contribute little, at least as a basis for individual decisions, although it may be possible to develop tests which can predict the outcome of psychotherapy. At present, trial psychotherapy appears to be the best selection method. In their present state, the use of tests in psychotherapy research may tell us more about the tests than about psychotherapy.

REFERENCES

1. Ash, P. The reliability of psychiatric diagnoses. *J. abnorm. soc. Psychol.*, 1949, 44:272-276.
2. Auld, F., Jr., & Eron, L. D. The use of the Rorschach to predict whether patients will continue in psychotherapy. *J. consult. Psychol.*, 1953, 17:104-109.
3. Auld, F., Jr., & Myers, J. K. Contributions to a theory for selecting psychotherapy patients. *J. clin. Psychol.*, 1954, 10:56-60.
4. Barron, F. An ego-strength scale which predicts response to psychotherapy. *J. consult. Psychol.*, 1953, 17:327-333.
5. Bordin, E. S. Diagnosis in counseling and psychotherapy. *Educ. psychol. Measmt.*, 1946, 6:169-184. Also in A. H. Brayfield (Ed.), *Readings in Modern Methods of Counseling*. New York: Appleton-Century-Crofts, 1950.
6. Bordin, E. S. *Psychological counseling*. New York: Appleton-Century-Crofts, 1955.
7. Brayfield, A. H., et al. Symposium: Personality tests in counseling.

- Annual Convention, American Psychological Association. New York, New York, August 31, 1957.
8. Carr, A. C. An evaluation of nine nondirective psychotherapy cases by means of the Rorschach. *J. consult. Psychol.*, 1949, 13:196-205.
 9. Cartwright, D. S. Success in psychotherapy as a function of certain actuarial variables. *J. consult. Psychol.*, 1955, 19:357-363.
 10. Cartwright, D. S. Methodology in counseling evaluation. *J. counsel. Psychol.*, 1957, 4:263-267.
 11. Cartwright, Rosalind D. Predicting response to client-centered therapy with the Rorschach PR Scale. *J. counsel. Psychol.*, 1958, 5:11-17.
 12. Cobb, S. Contemporary problems in psychiatry. In *Theory and treatment of the psychoses: some newer aspects*. St. Louis: Washington University Press, 1956.
 13. Combs, A. W. Problems and definitions in legislation. *Amer. Psychologist*, 1953, 8:554-563.
 14. Cuadra, C. A., & Albaugh, W. P. Sources of ambiguity in psychological reports. *J. clin. Psychol.*, 1956, 12:109-115.
 15. Davenport, Beverly F. The semantic validity of TAT interpretations. *J. consult. Psychol.*, 1952, 16:171-175.
 16. Elkin, F. Specialists interpret the case of Harry Holzer. *J. abnorm. soc. Psychol.*, 1947, 42:99-111.
 17. Filmer-Bennett, G. Prognostic indices in the Rorschach records of hospitalized patients. *J. abnorm. soc. Psychol.*, 1952, 47:502-506.
 18. Filmer-Bennett, G. The Rorschach as a means of predicting treatment outcome. *J. consult. Psychol.*, 1955, 19:331-334.
 19. Fricke, B., et al. Symposium: Structured versus unstructured personality tests. Annual Convention, American Psychological Association, New York, New York, September 3, 1957.
 20. Gallagher, J. J. A comparison of clients who continue with clients who discontinue client-centered therapy. In *Group report of a program of research in psychotherapy*. Pennsylvania State College: Psychotherapy Research Group, 1953.
 21. Gallagher, J. J. Test indicators for therapy prognosis. *J. consult. Psychol.*, 1954, 18:409-413.
 22. Gibby, R. G., Stotsky, B. A., Hiler, E. W., & Miller, D. R. Validation of Rorschach criteria for predicting duration of therapy. *J. consult. Psychol.*, 1954, 18:185-191.
 23. Gibby, R. G., Stotsky, B. A., Miller, D. R., & Hiler, E. W. Prediction of duration of therapy from the Rorschach test. *J. consult. Psychol.*, 1953, 17:348-354.
 24. Grayson, H. M., & Tolman, Ruth S. A semantic study of concepts of clinical psychologists and psychiatrists. *J. abnorm. soc. Psychol.*, 1950, 45:216-231.

25. Guertin, W. H. A factor analytic study of schizophrenic symptoms. *J. consult. Psychol.*, 1952, 16:308-312.
26. Guertin, W. H. An inverted factor-analytic study of schizophrenics. *J. consult. Psychol.*, 1952, 16:371-375.
27. Guertin, W. H. A transposed factor analysis of schizophrenic performance on the Bender-Gestalt. *J. clin. Psychol.*, 1954, 10:225-228.
28. Guertin, W. H. A factor analysis of schizophrenic ratings on the Hospital Adjustment Scale. *J. clin. Psychol.*, 1955, 11:70-73.
29. Guertin, W. H. A factor analysis of schizophrenics rated on the Activity Rating Scale. *J. clin. Psychol.*, 1956, 12:163-166.
30. Harris, R. E., & Christiansen, Carole. Prediction of response to brief psychotherapy. *J. Psychol.*, 1946, 21:269-284.
31. Hunt, W. A. Diagnosis and non-directive therapy. *J. clin. Psychol.*, 1948, 4:232-236.
32. Hunt, W. A., Arnhoff, F. N., and Cotton, J. W. Reliability, chance, and fantasy in inter-judge agreement among clinicians. *J. clin. Psychol.*, 1954, 10:294-296.
33. Hunt, W. A., Wittson, C. L., & Hunt, Edna B. A theoretical and practical analysis of the diagnostic process. In P. H. Hoch & J. Zubin (Eds.), *Current problems in psychiatric diagnosis*. New York: Grune & Stratton, 1953.
34. Jenkins, R. L. Symptomatology and dynamics in diagnosis: a medical perspective. *J. clin. Psychol.*, 1953, 9:149-150.
35. Kirk, Barbara A., & Headley, R. R. Factors related to voluntary discontinuance of contact during counseling. *J. consult. Psychol.*, 1950, 14:386-392.
36. Kirkner, F., Wisham, W., & Giedt, H. A report on the validity of the Rorschach Prognostic Rating Scale. *J. proj. Tech.*, 1953, 17:465-470.
37. Klopfer, B., Kirkner, F. J., Wisham, W., & Baker, Gertrude, Rorschach Prognostic Rating Scale. *J. proj. Tech.*, 1951, 15:425-428.
38. Kotkov, B., & Meadow, A. Rorschach criteria for predicting continuation in individual psychotherapy. *J. consult. Psychol.*, 1953, 17:16-20.
39. Lorr, M. The classification problem in psychopathology. *J. clin. Psychol.*, 1953, 9:143-144.
40. Lorr, M., Jenkins, R. L., & O'Connor, J. P. Factors descriptive of psychopathology and behavior of hospitalized psychotics. *J. abnorm. soc. Psychol.*, 1955, 50:78-86.
41. Lorr, M., O'Connor, J. P., & Stafford, J. W. Confirmation of nine psychotic symptom patterns. *J. clin. Psychol.*, 1957, 13:252-257.
42. Lorr, M., & Rubinstein, E. A. Factors descriptive of psychiatric outpatients. *J. abnorm. soc. Psychol.*, 1955, 51:514-522.
43. Luft, J. Implicit hypotheses and clinical predictions. *J. abnorm. soc. Psychol.*, 1950, 45:756-759.

44. McCue, Miriam, Goodman, M., & Rosenthal, M. Failure to return for treatment in tested and nontested clinic patients. *J. consult. Psychol.*, 1954, 18:280.
45. Meehl, P. E. Wanted—a good cookbook. *Amer. Psychologist*, 1956, 11:263–272.
46. Mehlman, B. The reliability of psychiatric diagnoses. *J. abnorm. soc. Psychol.*, 1952, 47:577–578.
47. Mindess, H. Predicting patients' responses to psychotherapy: a preliminary study designed to investigate the validity of the Rorschach Prognostic Rating Scale. *J. proj. Tech.*, 1953, 17:327–334.
48. Monroe, A. B. Psychiatric types: A Q-technique study of 200 patients. *J. ment. Sci.*, 1955, 101:330–343.
49. Muench, G. A. An evaluation of non-directive psychotherapy. *Appl. Psychol. Monogr.*, 1947, 13:3–163.
50. Myers, J. K., & Auld, F., Jr. Some variables related to outcome of psychotherapy. *J. clin. Psychol.*, 1955, 11:51–54.
51. Parloff, M. B., Kelman, H. C., & Frank, J. D. Comfort, effectiveness, and self-awareness as criteria of improvement in psychotherapy. *Amer. J. Psychiat.*, 1954, 111:343–352.
52. Patterson, C. H. Is psychotherapy dependent upon diagnosis? *Amer. Psychologist*, 1948, 3:155–159.
53. Pepinsky, H. B. Application of informal projective methods in the counseling interview. *Educ. psychol. Measmt.*, 1947, 7:135–140.
54. Pepinsky, H. B., & Pepinsky, Pauline N. *Counseling theory and practice*. New York: Ronald, 1954.
55. Redlich, F. C. Some sociological aspects of the psychoses. In *Theory and treatment of the psychoses: some newer aspects*. St. Louis: Washington University Press, 1956.
56. Roberts, L. K. The failure of some Rorschach indices to predict the outcome of psychotherapy. *J. consult. Psychol.*, 1954, 18:96–98.
57. Robinson, J. T., & Cohen, L. D. Individual bias in psychological reports. *J. clin. Psychol.*, 1954, 10:333–336.
58. Rogers, C. R. *Counseling and psychotherapy*. Boston: Houghton Mifflin, 1942.
59. Rogers, C. R. Psychometric tests and client-centered counseling. *Educ. psychol. Measmt.*, 1946, 6:139–144.
60. Rogers, C. R. The necessary and sufficient conditions of therapeutic personality change. *J. consult. Psychol.*, 1957, 21:95–103.
61. Rogers, C. R., & Dymond, Rosalind. (Eds.) *Psychotherapy and personality change*. Chicago: University of Chicago Press, 1954.
62. Rogers, L. S., & Hammond, K. R. Prediction of results of therapy by means of the Rorschach test. *J. consult. Psychol.*, 1953, 17:8–15.
63. Rogers, L. S., Knauss, Joanne, & Hammond, K. R. Predicting continu-

- ation in therapy by means of the Rorschach test. *J. consult. Psychol.*, 1951, 15:368-371.
64. Rosenberg, S. The relationship of certain personality factors to prognosis in psychotherapy. *J. clin. Psychol.*, 1954, 10:341-345.
65. Rubinstein, E. A., & Lorr, M. A comparison of terminators and remainers in outpatient psychotherapy. *J. clin. Psychol.*, 1956, 12:345-349.
66. Rubinstein, E. A., & Lorr, M. Patient types in outpatient psychotherapy. *J. clin. Psychol.*, 1957, 12:356-361.
67. Sarbin, T. R. Clinical psychology—art or science. *Psychometrika*, 1941, 6:391-400. Also in A. H. Brayfield (Ed.), *Readings in modern methods of counseling*. New York: Appleton-Century-Crofts, 1950.
68. Schmidt, H. O., & Fonda, C. P. The reliability of psychiatric diagnosis: a new look. *J. abnorm. soc. Psychol.*, 1956, 52:262-266.
69. Seeman, J. Counselor judgments of therapeutic process and outcome. In C. R. Rogers & Rosalind Dymond (Eds.), *Psychotherapy and personality change*. Chicago: University of Chicago Press, 1954.
70. Snygg, D., & Combs, A. W. *Individual behavior*. Harper, 1949.
71. Stainbrook, E. Some historical determinants of contemporary diagnostic and etiological thinking in psychiatry. In P. H. Hoch & J. Zubin (Eds.), *Current problems in psychiatric diagnosis*. New York: Grune & Stratton, 1953.
72. Stanton, A. H. Theoretical contribution to the concept of milieu therapy. In *Theory and treatment of the psychoses: some newer aspects*. St. Louis: Washington University Press, 1956.
73. Strecker, E. A. General principles of psychiatry and psychotherapy. In H. A. Pattison, *The handicapped and their rehabilitation*. Springfield, Ill.: Thomas, 1957.
74. Sullivan, P. L., Miller, Christine, & Smelser, W. Factors in length of stay and progress in psychotherapy. *J. consult. Psychol.*, 1958, 22:1-9.
75. Szasz, T. S. Some observations on the use of tranquilizing drugs. *A.M.A. Arch. Neurol. & Psychiat.*, 1957, 77:86-92.
76. Taulbee, E. S. Relationship between certain personality variables and continuation in psychotherapy. *J. consult. Psychol.*, 1958, 22:83-89.
77. Taylor, J. W. Relationship of success and length in psychotherapy. *J. consult. Psychol.*, 1956, 20:332.
78. Thorne, F. C. *Principles of personality counseling*. Brandon, Vt.: Journal of Clinical Psychology, 1950.
79. Thorne, F. C. The Prognostic Index. *J. clin. Psychol.*, 1952, 8:42-45.
80. Williamson, E. G. *Counseling Adolescents*. New York: McGraw-Hill, 1950.
81. Wittenborn, J. R. Symptom patterns in a group of mental hospital patients. *J. consult. Psychol.*, 1951, 15:290-302.

82. Wittenborn, J. R. The behavioral symptoms for certain organic psychoses. *J. consult. Psychol.*, 1952, 16:104-106.
83. Wittenborn, J. R., & Bailey, C. The symptoms of involutional psychoses. *J. consult. Psychol.*, 1952, 16:13-17.
84. Wittenborn, J. R., & Holzberg, J. D. The generality of psychiatric syndromes. *J. consult. Psychol.*, 1951, 15:372-380.
85. Wittenborn, J. R., Holzberg, J. D., & Simon, B. Symptom correlates for descriptive diagnosis. *Genet. Psychol. Monogr.*, 1953, 47:237-301.
86. Wittenborn, J. R., & Weiss, W. Patients diagnosed manic-depressive psychosis-manic state. *J. consult. Psychol.*, 1952, 16:193-198.
87. Windle, C. Psychological tests in psychopathological prognosis. *Psychol. Bull.*, 1952, 49:451-482.
88. Wyatt, F. Climate of opinion and methods of readjustment. *Amer. Psychologist*, 1956, 10:537-542.
89. Zilboorg, G. *A history of medical psychology*. New York: Norton, 1941.
90. Zilboorg, G. Rediscovery of the patient: an historical note. In Frieda Fromm-Reichmann & J. L. Moreno (Eds.), *Progress in psychotherapy —1956*. New York: Grune & Stratton, 1956.

PART IV

.....

SOME QUESTIONS

CHAPTER 11

Is Depth Psychology Necessary?

The observant reader will have noticed that no use has been made of such concepts of depth psychology as the unconscious, repression, instinctive forces or drives, even motivation. Yet the acceptance of depth psychology is almost universal in clinical psychology and psychiatry. It seems to be desirable to contrast non-depth psychology as developed in this book, with the concepts and therapeutic approach of depth psychology.

In this chapter we shall briefly indicate the nature of depth psychology, and then summarize a nondepth approach to behavior, the phenomenological field theory adopted in this book. Emphasis is placed on perception, since this is viewed as the central element in behavior. Differences in the approach to psychotherapy of a depth psychology and the nondepth phenomenological approach will then be considered briefly. Finally, we shall touch upon psychotherapy as learning from the phenomenological point of view in contrast to attempts to adapt other learning theories, such as reinforcement, to a depth theory of personality and behavior. Emphasis is placed upon the necessity for taking a unitary view of all human behavior, rather than developing separate, fragmentary theories of the various aspects of behavior. It is concluded that such a unitary theory need not be a depth theory in the usual

clinical usage of this term, but that a phenomenological theory appears to be fruitful in integrating present knowledge and suggesting further research.

DEPTH PSYCHOLOGY

The beginning of depth psychology was the discovery of the unconscious by Freud. The origins of Freud's ideas about the unconscious lie in his work with hysterics. Freud observed many cases of organic symptoms with no organic basis. He learned that these symptoms could be removed, first by hypnosis, and later by psychoanalysis. It was therefore evident that they were psychological in nature; Freud saw a relationship between the symptoms and psychological conflicts within the individual, in which the conflict was "converted," without awareness on the part of the individual, into physical symptoms. Freud developed a topographic model to explain the process by which psychological conflicts or forces manifested themselves in physical symptoms, or sometimes in other forms of behavior such as amnesia, obsessions, and compulsions, or even multiple personalities. Since the individual was unaware of the process, or the connection between his behavior and the psychological factors, Freud used the term unconscious in discussing the process. But he went beyond a descriptive use of the term and posited an unconscious area of the mind in which the forces of the id and superego clashed, with the superego seeking to repress the id, and the id breaking through the repression in the form of disguised behavior, or symptoms.

Freud early extended his concept of the unconscious motivation of behavior from the abnormal to the normal in his *Psychopathology of Everyday Life* (12). The widespread acceptance of the concept suggests that he has succeeded far more than has perhaps been realized in impressing his ideas upon not only the professions of psychology and psychiatry but upon the general public as well. The result is that in the minds of many people nothing is as it

seems, and everything has a different significance than appears upon the surface. In extreme form it leads to the interpretation of behavior, or at least verbalization, as indicating the opposite or reverse of its apparent meaning. "In present day clinical psychology (and, of course, in the related field of psychiatry), one never does things for very obvious reasons—especially if psychopathology is involved—but for hidden or subverted reasons. It is the 'unconscious' mind that is working, not the 'conscious' mind" (33, p. xii).

Somewhat the same attitude prevails in those psychologists who are most attached to depth psychology, the projective testers. Projective techniques are assumed to reach the deeper levels of personality and motivation. Unfortunately, there is no way of knowing what level is being tapped. Thus, when the results of the tests are consistent with other knowledge about the subject, such as current overt behavior or verbalizations, the tests are taken as being validated. But on the other hand, when there is disagreement, it is contended that the tests are measuring repressed or unconscious tendencies or motivations. So far, however, there appears to be no adequate evidence that this is so.

All inferences about personality or behavior must be tied in with overt behavior somewhere, or they are useless. The results of evaluating projective techniques against behavior are mainly negative, however (8). If such measures are not validated, they are of little value, either in predicting behavior or understanding the individual. Possibly interpretations of projective materials reveal more about the interests and motives of the interpreter than they do about the subject. Smith, Bruner, and White (48) conclude that a man's expressed opinions and values are more indicative when it comes to prediction than are projective techniques.¹

¹ Projective techniques are not necessarily depth techniques. It is their use which has made them such. As approaches to the study of perceptions, they may be used as devices for the study of nondepth, or field theoretical psychology. Rogers (36) summarizes a study by Alice Jonietz (A study of the phenomenological changes

The failure to validate experimentally depth techniques poses a problem. The question may legitimately be raised as to whether the failure may not be taken to indicate that possibly what is sought for does not exist, that many of the concepts of depth psychology are illusory. The abandonment of depth psychology may strike some as anathema or iconoclastic. Yet it is the function of science to question existing concepts no matter how deeply entrenched or widely accepted they are.

Whyte (53, p. 40) has raised the question from outside psychology. He writes: "Someday someone is going to create a stir by proposing a radically new tool for the study of people. It will be called the face-value-technique. It will be based on the premise that people often do what they do for the reasons they think they do. The use of this technique would lead to many pitfalls, for it is undeniably true that people do not always act logically or say what they mean. But I wonder if it would produce findings any more unscientific than the opposite course."

As a matter of fact, this technique is not, of course, a "radically new tool." Most of the work in advertising and public opinion polling has, until very recently, been based on this approach. It is a real question whether the developing methods of "motivational research" (see Chapter 6), with their projective tests and depth interviews, will be as effective or as successful as the "face-value approach." The results of the work by Smith, Bruner, and White (48) would suggest not.

Some psychologists are raising questions about some of the concepts of depth psychology. Postman (34), for example, asks: "Is the concept of motivation necessary?" Krech (19, p. 111) has called motivation "an outmoded and unnecessary concept."

Actually, we have had nondepth theories and systems of psychology with us constantly. Watsonian behaviorism was certainly

in perception after psychotherapy as exhibited in the content of Rorschach percepts. Unpublished doctoral dissertation, University of Chicago, 1950) in which the Rorschach was used in this manner. See also Klein (18, pp. 343, 344).

not a depth psychology, nor are the neobehavioral schools. But are we limited to a choice between depth psychology and neobehaviorism—or perhaps to an attempted reconciliation or mixture of the two such as that of Dollard and Miller (10)? As a matter of fact, we are not. Gestalt psychology is a nondepth psychology, and its developments and adaptations, by Lewin (20, 21, 22) in his ahistorical, nongenetic psychology, and by Snygg and Combs (49) in phenomenology offer a systematic approach to human behavior. And recently two other nondepth models have been proposed: the “interference theory” of Phillips (33), and the psychology of personal constructs of Kelly (17), both cognitive perceptual models.

While the concept of the unconscious as an entity or localization of the mind is unacceptable, and actually no longer held by most depth psychologists, the fact that the individual is often not aware of the factors influencing his behavior is a significant contribution of Freud (30). These factors of which the individual is unaware may be part of the unconscious, as distinguished from what is in awareness, or is conscious. A further contribution of Freud consists of the suggestion that the elements which do not appear in awareness are not always merely forgotten, but are prevented from reaching awareness. There is thus differential recall (selective forgetting), or degrees of availability of past experiences to awareness, which is related to personality disturbances. Freud accounted for this phenomenon by the concept of repression. In a nondepth psychology this phenomenon is related to narrowed or selective perception, resulting from threat.

The phenomena which Freud observed were significant and require explanation. His explanations, in terms of depth concepts, or what Meehl (33, p. vi) calls the historical-geological-hydraulic model, are not necessarily valid. Nevertheless, these concepts may be parallel to, and translatable into, other nondepth concepts. Bronfenbrenner (3) attempts to “translate” Freud into Lewin’s field theory.

Depth psychology is characterized by explanations in terms of what Phillips (33, p. xii) calls the "push-from-behind" element, while field theoretical psychology is characterized by explanations in terms of the influence of current perceptions. Smith, Bruner, and White (48, p. 20), referring to the period of the application of psychoanalysis to social phenomena, state that "Explanation in this period was always from the inside out, never from the outside in."

The above discussion is not to be taken to mean that we should abandon concepts of latent determinants of behavior, and accept all surface or manifested behavior at face value. Behavior often has meanings other than the apparent, of which the behavior is unaware. Inferences about underlying determinants of behavior often resolve apparent discrepancies in observed behavior characteristics. Psychoanalysis itself, however, beginning with Anna Freud's analysis of the ego,² has become less depth-oriented, as Frenkel-Brunswik (11), among others, has pointed out. She also notes that "with the greater emphasis on perception and cognition, as well as on social factors, personality theory is reintroducing the manifest personality phenotype" (11, p. 375).

It is the extreme reliance on depth concepts to which we are objecting here. Clinical psychology and psychiatry do not yet appear to have been greatly influenced by the trend from depth theory in psychoanalysis and personality theory. There is still apparent the error "of overinterpretation and of making far-reaching conclusions on the basis of insufficient material evidence" (11, p. 358), with failure in "making fully explicit the relationship between the inference involved and the observational data" (11, p. 360), and inadequate attention to the relating of dynamic concepts to behavioral data. And as Smith, Bruner, and White (48, p. 39) note in relation to certain points in their study, "it seems to us that parsimony is on the side of shunning the dynamic explanation in favor of the less glamorous description."

² Anna Freud. *The ego and the mechanisms of defence*. London: Hogarth Press, 1937.

PHENOMENOLOGICAL FIELD THEORY AND PERCEPTION

Since perception is central in a phenomenological theory of behavior—indeed, to any theory of behavior—it seems desirable to consider the nature of perception. In this section the classical or traditional approach to perception will be compared with the developing approach as influenced by phenomenological field theory.

The assumption that behavior is determined or motivated by unconscious factors is, as Phillips and Snygg and Combs (33, 49) point out, not an inevitable one but one based on the selection of the causal field. Causality may be attributed to forgotten historical events, which may be called unconscious, from the frame of reference of the observer. But the frame of reference of the behavior may also be adopted, in which case it is not necessary to look for a historical cause, either for understanding or predicting behavior. That is, "all behavior is determined by (and pertinent to) the phenomenological field at the moment of action" (49, p. 45). As Phillips puts it (33, p. 99), ". . . as a theorist or as a practitioner, one is in a better position to understand the subject . . . if he deals with the perceptually present events than if one assumes that dark, inaccessible forces account for the observable events."

This point of view has been difficult for some to accept for two reasons:

1. The concept of causality has tended to include a time span, and it seems to be habitual to pursue analysis back to so-called ultimate causes. It is difficult not to take the observer's point of view and to explain in terms of preceding historical events. But causality is a difficult concept to define or defend, and if it is viewed operationally, as it must eventually, as a universally preceding condition, then the closer the condition is to the event, the more defensible it would appear to be to assert a causal connection. This point of view does not, as some have apparently assumed, mean that earlier events do not affect later occurrences in an individual's life. But these earlier events are influential (a)

only if they affect the present perceptual field, and (b) not as objective physical events in themselves, nor even as they were perceived when they occurred but only as they are perceived at the present moment. Lewin has stated it well (22): "The behavior's field at any given instant contains also the views of the individual about his past and future. . . . The psychological past and the psychological future are simultaneous parts of the psychological field existing at a given time. . . ."

2. A second source of resistance in accepting the phenomenological point of view is based upon the hold the concept of the unconscious has upon us. There *must* be unconscious forces in our behavior. Apparent evidence for this is the fact that the behavior gives as reasons for his behavior, factors which are not acceptable to an observer. Whether a reason or cause is accepted as *the* cause depends upon the frame of reference. Moreover, consciousness seems to be equated with reportability, so that the fact that the behavior is not able to verbalize or to describe in words his entire perceptual field is taken as evidence of the existence of unconscious elements. There are varying degrees of awareness of the elements in the field. Perhaps a better way of stating it is that those things which are the ground, rather than the figure, in a perception are less well attended to, less clearly in focus, and thus less easily reported or verbalized. Phillips (33, p. 104) writes that "The small amount of full awareness (in the sense of articulate labeling) available or present at any given time-segment merely refers to the limits of perception in a physical or neurological sense, and to the still greater narrowing effected by the on-going assumptions operative in the person-environmental matrix. The latter observation H. S. Sullivan called 'selective inattention' . . ."

One of the difficulties of abandoning the concept of unconscious forces is the fact that not only is it applied to repressed forces seeking outlet, but it is often extended to include all effects of the past or present behavior which cannot be verbalized by the subject. For example, De Grazia (9, p. 259) writes: "Apart from

the lack of evidence, to ask whether the unconscious exists is to ask paradoxically whether memory exists. If memory exists, experiences can be recalled and relived (for memory involves a partial re-experiencing) but until recall they are unconscious. Thus if there were no memory, there would be no unconscious." But if memory and forgetting are coterminous with consciousness and unconsciousness, is there any purpose served by retaining both sets of terms? Certainly we recognize that nothing is forgotten in the sense that no trace of it remains in the nervous system (27).³ Past events or experiences influence present behavior without one being specifically aware of the experiences themselves. The process is thus unconscious. The difficulty with using this term is that it tends to be associated with a mysterious, autonomous force. There is a problem, however, regarding the selective nature of awareness or consciousness. Depth psychology posits a repressive force, while phenomenological field theory, as suggested above, assumes that certain experiences cannot be readily recalled because of their present threatening nature. The threat may exist without the individual's being aware of its nature.

Is this position concerning depth psychology inconsistent with the experiments on personal values and need in perception, referred to in Chapter 9? These studies have shown that an individual's perceptions are influenced by his values and needs. But do not these influences operate on an unconscious level? Again, it is a matter of choice of explanatory concepts. While the influence can be attributed to unconscious forces, it is not necessary to do so. There is no "breaking through" of repressed impulses, but only the operation of learned attitudes in the perception of the object or situation. There may, of course, be sudden or strong perceptions of attitudes, feelings, or emotions, which have not heretofore been

³ The work of Penfield (32) provides experimental evidence for this statement. Electrical stimulation of the surface of the temporal lobe cortex results in the reliving of past experiences by the subject while he still is aware of his present surroundings. It is interesting that it is the entire situation which is revived, not a distorted memory trace.

in awareness. The subject may not be able to verbalize the nature or origins of the attitudes, i.e., they may not be available to easy or direct recall, but it is the present expression of these attitudes, not their origin, which determines perception and behavior.

Threat, as we have suggested earlier (Chapter 7), affects perception by narrowing the perceptual field. This restriction prevents the appearance of certain elements, including memories, in the field. The individual doesn't "see" aspects of the situation, such as alternative or possible solutions to a problem. This effect has been experimentally demonstrated in studies of the effect of mental set and anxiety on learning and problem-solving. The result of this narrowing or restricting of perception is the rigid, stereotyped repetitive behavior observed by Maier (25) in his rats. This is perhaps the same kind of behavior in humans which was labeled "repetition compulsion" by Freud. This behavior is not the result of unconscious autonomous forces, but of narrowed perception of the situation. This narrowed perception is manifested visually by what is called "tunnel vision," and may also be related to the severe elimination of the perception of whole areas of experience which constitutes amnesia.

The basic tenet of a phenomenological field theory is that the individual's frame of reference is not some "reality" or physically real world, but a personal, private world. This is, to him, the real world, since it is the only world he knows (29, p. 365). It is the world as he perceives it. Perception has been defined as meaningful sensation, and the meanings are not all given by the stimulus, but by the organism which is stimulated.⁴ It is probably desirable, as Gestalt psychology has done, to discard sensation as a concept, since all sensations are meaningful, i.e., interpretations of the stimulus, and to think in terms of stimulus and perception only. Gibson (14, p. 94) states the point of view when he says that

⁴ "The individual sees what he wants to see, not in the sense that he manufactures out of whole cloth but in the sense that he appropriates to himself, from what is given, the pattern that he needs" (28, p. 218).

"... students of social perception . . . are sure that the doctrine of the passive perceiver who simply mirrors the world is a myth and is now disposed of for good. What a man perceives . . . depends on his personality and his culture." Again, stated in extreme form, "We see things not as *they* are but as *we* are" (14, p. 98).

Now this view of perception is one which is at variance with the classical view. The latter assumes the existence of a physical reality, or true world, and has been interested in studying the nature of the perception of this world by means of psychophysical methods. The psychophysicists or psychophysiologists are interested in the study of the stimulus determinants of perception. The "true" perception is the average; individual differences are due to "error." A classical example of this is the reported dismissal of an assistant at Greenwich Observatory in 1796 because he continually reported the time of transit of stars a fraction of a second later than did his master. Bruner, outlining a theory of perception, states:

Above all, such a theory of perception should account systematically for individual differences in the perceptual process and not assign them to random error. . . . In future research, we must, I think, seek to maximize the constant errors and, what is more, cease calling them by the old-fashioned statistical name of errors. Let the word "error" apply only to that portion of the total variance which can be attributed to no source. This is our error, not the subject's. A personality-oriented perceptual theory precisely needs laws to account for the systematic judgmental and perceptual tendencies of different groups of people displaying different personality patterns—not just general laws of perception each embellished with a statement of variance (4, p. 123).

Klein (18) has put this concept to use in a series of studies in perception.

The work on the influence of values and needs on perception, referred to earlier, has focused attention on the importance of nonstimulus determinants in perception. These experiments have been criticized, on the basis that "Their experiments are designed

to maximize the noncorrespondence of perception to stimulation whereas the psychophysical experiment is designed to maximize the correspondence of perception to stimulation" (14, p. 95). Perhaps the psychophysical experiments should be criticized also for their one-sided approach. The critics tend to categorize the individually determined perceptions as misperceptions or distortions. But what is "misperception," if not merely a difference from an average? What is "true perception," if not merely an average, or the agreement of a number, or majority, of observers? In the case of simple, clear, unambiguous stimuli, agreement may be general, with little variability. But for complex, undifferentiated, unstructured, ambiguous situations, such as many, if not most, personal-social-cultural situations, personal factors are important, and lead to differences in perception. The psychophysiologists insist that even in these cases there are real or true stimuli which have a "correct" perception. While this may be so, it is often not possible to identify the "real" or objective stimulus, and for the understanding of responses or behavior actual perceptions are important.

Gibson (14, pp. 94-95) concedes that ". . . all perception is in a certain sense socialized perception," but insists that ". . . all perception is just as truly psychophysical perception." He feels that "Only to the extent that stimulus-determination fails do we need to assume that the influence of attitude, expectation, assumption, or past experience is exerted." This may be true, if by failure of stimulus determination we mean, as it seems we must, only that these other influences exist, not that there is a "failure" in the stimulus.

Gibson apparently sees these two aspects as mutually exclusive. He states (14, pp. 99-100) that "The central issue in contemporary theories of perception is whether to emphasize one or another of two contradictory propositions, the first that perception depends on stimulation, and the second that perception does not depend on stimulation but on something else," such as set, motivation, atten-

tion. But what is wrong with the acceptance of both propositions, as supplementary rather than contradictory? Actually, Gibson does so when he proposes two kinds of perceptual theory which are supplementary. These he bases on two kinds of perception, however, one "literal" observation and the other "schematic." The first is the perception of the world as established by psychophysical experiment, the real or enduring world. The second yields "a selected and simplified world, the specific problem-situation relevant to present needs, . . . an immediate and temporary kind of perception" (14, p. 102). He conceives this kind of perception as being essentially misperception, "erroneous," "distorted," "misleading," because we are "victims of our stereotypes," and "de-luded by our social norms" (14, pp. 103-104).

Again, while one may agree that there is a reality, a "true" stimulus, it remains that, whether the stimulus is a simple physical one or a complex social one, we can never know it. All we can know are our perceptions, and it appears to be undesirable to use the term misperception except possibly as a *judgment* applied to perceptions which differ greatly from the average. Even an illusion which is perceived by the majority of people, such as the standard Müller-Lyer illusion, the phi phenomenon, and autokinesis, should not be labeled misperception. They are true perceptions, even though false to the physical stimulus.

It appears to be possible, if one thus separates perception from stimulation, to develop a theory of perception which is unitary. In this theory, which appears to be necessarily phenomenological, both characteristics of the stimulus and characteristics of the observer influence perception. *All* perceptions are influenced by *both* the stimulus and the observer. In some cases the first influence is dominant. In these cases we have little or no disagreement among observers on what is perceived. In other cases the influences from the observer are paramount, and in these cases we have considerable disagreement. The perceptions of all observers are true perceptions even though different.

Characteristics of the stimulus which influence perceptions include clarity or ambiguity (including structuredness and figure-ground relationships), and simplicity or complexity. Characteristics of the observer include attention, set, needs, goals, values, attitudes, interests, etc. Gibson notes that Titchener pointed out only a small part of the environment is clear at any moment, because of the limits of apprehension in terms of time and space. Perception is thus selective, and the selection is made on the basis of the personal-social characteristics of the individual observer. The effective environment thus varies, depending on the characteristics of the individual.

There are thus not two kinds of perception. All perception is to some extent social perception, but to varying degrees. The same stimulus may be perceived differently by different persons, or by the same person at different times, depending on the nature and strength of the personal determinants of perception. In psychologically significant behavior, these personal elements are strong, and it is therefore important that they be recognized and understood. It is for this reason that emphasis has been placed on them by psychologists interested in personality and social behavior.

Gibson (14, pp. 105-108) has suggested some of the concerns of this aspect of perceptual theory. He includes the recognition of different perceptions of the same external stimulation in different situations. Changes in perceptions, both in the direction of increasing differentiation and increasing generalization, must be included in the theory. The influence of culture on perception through verbal naming, and communication of these names or concepts must be recognized.

Such a theory is clearly a social phenomenological theory. However, Gibson (14, p. 105) sees it as being developed by the method of the psychophysical experiment. This could be true only if such experiments included in them the variables within the observer as independent variables, and did not seek to reduce individual or group differences to errors in the perception of a "true"

stimulus. For the understanding of human behavior, these differences are important, not the so-called "reality" which is no more than majority agreement on what is "out there."

DEPTH PSYCHOLOGY, PHENOMENOLOGY, AND PSYCHOTHERAPY

Adherents to a depth psychology appear to have in common certain techniques of psychotherapy. It also appears that they have a common attitude toward patients or clients, although this attitude probably varies considerably in its strength. In its extreme form it is manifested in a lack of acceptance of or trust in the client. Since nothing is as it seems, or can be accepted at face value, the client's statements cannot be accepted as accurate. It is not that the client is seen as deliberately misrepresenting things or lying, but that he is unable to tell the truth. He doesn't know himself or the truth, his motivations, or the reasons for his behavior, since these are repressed, unconscious, or at least distorted. Wyatt (55) states the attitude clearly: "We cannot any more accept on face value what people say about themselves and about others who matter to them. The therapist who deals with their problems, or the social scientist who attempts to understand the principles underlying them, will have to distinguish in many instances three levels of 'reality.' . . ." Skinner (46, p. 95) writes that "The testimony of the individual regarding his mental processes, feelings, needs and so on, is, as the psychiatrist above all others has insisted, unreliable."

Depth psychotherapy is pessimistic in its approach. Its assumption is that the client cannot help himself even if he wants to. The therapist must therefore take the initiative, and in effect force the client to dredge up and face the experiences and ideas buried in the depths of the unconscious. Meehl, in his preface to Phillips (33, p. v) speaks of the "pervasively negative perception of the patient held by depth therapists." Phillips (33, p. 121) suggests that "the person is judged to be bad when he's good, and to be bad when he's bad."

Depth therapy attempts to get behind the manifest content. It searches in the past for significant events. Depth therapists aim at the recovery of unconscious memories, at the lifting of the so-called "infantile amnesia." Therapy is usually considered successful to the extent that the unconscious is made conscious; or at least the uncovering and understanding of the unconscious origins of the client's problems is considered to be essential before symptoms can be eliminated or emotional difficulties alleviated (e.g., 13, p. x). Even the neoanalysts of the interpersonal school of Sullivan, though dealing with current problems of the client, seek for unconscious origins and motivations and explore childhood memories and experiences in the search for them.

The achievement of insight into such origins, however, is not automatically or always accompanied by improvement (31). Nor is improvement necessarily accompanied by such insight and understanding. Therapy, therefore, is not necessarily successful when the unconscious is made conscious, or when the therapist's depth interpretations are accepted. Depth therapy attempts to answer the question "why," in historical terms. But the answering of this question does not appear to be necessary for successful therapy. In fact, it is questionable if even the answering of this question in terms of the present phenomenal field is necessary for a change in that field. It appears that the removal of threat is the significant condition which makes possible a change in, or a restructuring or a widening of, the perceptual field, which is essential for a change in behavior.

If behavior is determined by the individual's perception, it can change only as these perceptions change. Therapy is successful, then, only as it makes possible changes in the client's perceptions (6, 7, 35, 36). As has been indicated earlier, such changes in perception can occur only in the absence of threat, which leads to rigidity and narrowing of the perceptual field.

The important determinant of behavior is thus not "reality" as seen by the observer, be he therapist or scientist, but the indi-

vidual's perceptions of reality. While it may be useful and interesting to trace the origins of these perceptions back in the history of the individual, this is not sufficient for effecting changes in them. It can be, in fact is in many cases, threatening to the client in therapy, and leads to so-called "resistance." The reality which the therapist must accept and deal with is the perceptual field of the client. This requires that the therapist be able to take the internal frame of reference of the client. The therapeutic techniques which then lead to changes in perception are discussed in Chapter 8. In terms of the present discussion, the therapeutic situation enables the client to widen his perceptions, to become aware of other elements, which opens possibilities for changes in reactions or behavior.

The concept of unconscious forces, of repression as a force, is unnecessary either to guide or to explain the process and results of psychotherapy; at best some of them may be descriptive. The use of the concepts of phenomenological psychology offers a sufficient explanation, on a simpler basis. It is not necessary to resort to animistic concepts of competing forces within the individual. The one common, major drive or motivation of the individual—the preservation and enhancement of the self—is sufficient for explanation of all the phenomena of behavior. The world is perceived in terms of its possibilities for satisfying or frustrating this need of the individual. Those aspects which lead to frustration become threats. Under threat, behavior shows certain characteristics, including the altering of perception. The altered perception, rather than repressive forces, limits or prevents the recognition, or recall, of pertinent experiences. These experiences are thus not represented in the perceptual field, and cannot affect behavior.

The prerequisite for behavioral change is a change in the perceptual field. This change becomes possible only when threat is removed. The therapeutic relationship offers a nonthreatening situation in which a widening or reorganization of the perceptual field becomes possible. This opens the way for the inclusion, or

recognition, of new alternatives or possibilities of behavior, a change in the self-concept which frees the individual for playing new roles, acquiring new experiences, and perceiving his environment and his relation within it in a new light. This is the basis of the changes in personality and behavior which we call therapeutic. Insight is the awareness or recognition of the changes in the perceptual field.

PSYCHOTHERAPY AS A LEARNING PROCESS

The interest of psychologists in psychotherapy has inevitably led to the analysis of psychotherapy as a learning process. There seems to be no disagreement that therapy is a learning process. But there has been little success in describing this process in acceptable systematic terms.

On the one hand there are several methods of counseling or psychotherapy, and on the other hand in psychology there are several learning theories. The approach to psychotherapy as learning has naturally led to the attempt to correlate learning theories with methods of psychotherapy, or to explain the processes of psychotherapy in terms of a learning theory.

In this attempt, the depth approaches to psychotherapy have not been particularly amenable to interpretation, explanation, or understanding in terms of existing theories of learning, at least without considerable modification, stretching, or forcing on one or both sides. The most detailed work in this direction is the attempt of Dollard and Miller (10) to integrate Hullian behaviorism with psychoanalysis. The results are not satisfying.

Attempts to start from learning theory and to describe the process of psychotherapy, without regard to a particular approach to therapy, have not been particularly successful. Shoben (42, 43, 44, 45), Shaw (39, 40, 41), and Magaret (24) have made such attempts. The comment of Combs (7) seems appropriate here. He writes: "Our existing learning theories, for the most part, are concerned with small bits of the problems encountered in coun-

seling. They seem to have little application beyond the simplest behavior, while the behavior of clients is complex and involving entire personalities. . . . What appears to happen to clients in counseling is a matter of personality reorganization calling for much broader concepts of learning than most present theories of learning even attempt to deal with."

The interesting experiments in operant conditioning by Greenspoon, Verplanck, and others (5, 15, 16, 23, 26, 51, 52, 54) indicate that verbal and motor behavior can be changed, in the interviewing situation as well as in other situations, by the use of this technique of conditioning, or learning. Such changes in behavior can occur without the awareness of the subject. These experiments suggest that conditioning theory might be applied to psychotherapy. Certainly such theory does not involve any depth concepts. The experiments so far have been mainly limited to simple behavior. However, one study (23) reports general improvement in behavior in a chronic deteriorated schizophrenic as a result of an operant conditioning program utilizing a machine. Although the extent and persistence of such improved behavior is not known, the approach poses a problem in terms of the basic assumptions of client-centered therapy. Even if the approach is successful on an extensive and "permanent" basis, the change of behavior might tend to leave the individual an automaton. The patient reported on regressed again when subjected to experimental extinction.

No attempt has been made to reconcile these results with client-centered theory, and perhaps it is not necessary to do so at this stage. While providing a method of controlling human behavior, the approach may be rejected on the basis that such control is not a goal of psychotherapy (see chapters 6 and 12). Rogers (38) does suggest that a common element is a trustworthiness (or consistency) in the situation whether the control is a machine or a therapist. Perhaps the results can be interpreted as due to a

changed perception of the environment, whether or not the subject is aware of it in terms of being able to verbalize the change.

If the results can be so interpreted—or even if they cannot at this stage—it appears to the writer that the most generally effective and applicable theory of learning in psychotherapy is the phenomenological or perceptual field theory of learning. This is the theory which has been developed in this book and specifically applied in this chapter as an explanation for therapeutic personality change. This is the theory implicit in the conditions of client-centered therapy. It is a theory which is nondepth-oriented and thus fitted to a nondepth therapy.

The statement of this theory in terms of the changing of behavior (i.e., learning) occurring in psychotherapy has been made by Combs (6, 7) and Rogers (35, 36, 37). The simple outline may be presented here as a summary of materials presented in earlier chapters and earlier in this chapter.

1. All behavior is determined by the perceptual field of the individual at the moment of action.
2. A significant—perhaps the most significant—aspect of the individual's perceptual field is his concept of himself.
3. A change in behavior is contingent upon a change in the perceptual field. *Learning is thus a result of changes in perception*, including differentiation of elements, or figure and ground. The techniques of psychotherapy therefore are directed toward establishing the conditions under which changes in the perceptual field can occur.
4. Changes in perception in the direction of improved mental health can occur only in the absence of threat. Threat leads to a narrowing or distortion of the perceptual field, and to rigid, stereotyped, maladaptive behavior. The self is defended against change. In a situation which is free from threat, the individual is able to explore his perceptions of himself and his environment, to recognize and to accept new experiences and elements into this perceptual field. A change in behavior, i.e., learning, is thus possible.

This frame of reference is one which, as Combs (7) indicates, encompasses and integrates a broad variety of problems, points of view and research, in perception, learning, clinical psychology, and psychotherapy. While this area is still relatively undeveloped, it

seems to be capable of leading to fruitful research and to an integrative theory of human behavior. Numerous experiments concerning the influence of mental set on problem-solving, on rigidity and stereotypy in problem-solving, such as the water-jar experiments, on the nature of insight in problem-solving (Koehler, Maier), as well as the recent work on the influence of values and needs in perception, can be interpreted as experimental evidence supporting the phenomenological approach. The review, analysis, and integration of the experimental literature is beyond the scope of the present chapter, however.

Questioning of this approach sometimes centers on the origins of one's perceptions, or the determinants of the perceptual field (45). Perception is influenced by both external and internal factors. The environment of course enters into perception. External objects or stimuli exist. But their "real" qualities can never be known; they are only and always apprehended through the senses of the individual. The fact that for many of the simple physical perceptions most people agree on what they see leads us to overlook this fact, and to fail to recognize the significance of differing perceptions of the environment. Of more significance in individual differences in behavior than the external factors in perception are the internal factors, which lead to varying perceptions of the same object or situation by different individuals.

The depth-oriented critic inquires about the origins of these determinants of the perceptual field. Certainly they are influenced by the previous experience of the organism; i.e., they are learned. But all previous experiences are based on previous perceptions of the environment, which develop from the same two sources—the external environment and the nature of the organism and its needs. An important part of the external environment is the social environment, the family and society in which the individual lives. This part of the environment is important in influencing the perceptions of the individual growing up in it. It defines the meaning of most aspects of the physical environment. These meanings

are passed on to the child by the process of communication. Thus the perceptions of the adult, and of the society, are transferred to the child.

This explanation of the origins of the determinants of the present perceptual field does not require any depth concepts. And while it is of interest, and of scientific value, to study these origins, it is not necessary to know or understand the historical origins of the present perceptual field in order to achieve a knowledge of that field, either for therapeutic, evaluative, or predictive purposes (49, 50).

We have attempted in this chapter to show that a depth approach to human behavior and psychotherapy is unnecessary, and in fact inefficient and limited. Such an approach does not lend itself to integration with any of the existing psychological theories of learning. While attempts have been made to view the therapeutic process and therapeutic personality change in learning terms, the only such approach which appears to be comprehensive enough to encompass the variety, complexity, and nature of such changes is a field theory of learning, or a phenomenological approach to human behavior. The broad outline of this theory, which is applied to the process of psychotherapy in this book, has been presented. There are many unsolved problems, of course. But it appears to the writer that no theory of human behavior can ignore perception; in fact it must be based on perception, which is the organism's contact with its environment, its source of information. The concept of learning as change in perception appears to be capable of integrating all current theories of learning. While it may be descriptive rather than explanatory, it directs attention to aspects of experience which influence perception. The investigation of "causes" of or factors in perception and changes in perception may result in the acceptance of various "kinds" of learning, in various fields, including contiguity, conditioning, reinforcement, and cognitive, all of them tied together by the common element of a resulting change in the perceptual field.

Any theory of human behavior must be broad enough and inclusive enough to apply to all behavior. We cannot have theories of perception, of cognition, of motivation, of learning, except as parts of a theory of human behavior. Krech (19, p. 130) points out, for example, that "since in our actual work we have not been able successfully to isolate so-called cognitive behavior from so-called motivational behavior, . . . therefore there is the very strong possibility that it will be unnecessary for us to hypothesize two types of neurological constructs." Since behavior and experience are unitary, all behavior has motivational, emotional, and intellectual aspects. Krech (19) proposes a unitary hypothetical construct which he calls a Dynamic System. An alternative is a phenomenological field theory such as the one used here. The two are similar in accepting a unitary basis for behavior. In phenomenological theory, motivation, learning, perception, and cognition are aspects of behavior resulting from different ways of viewing or describing the phenomenal field. The need for the preservation and enhancement of the self is, in this respect, a description of the functioning of a living, human organism in its environment. As Krech (19, p. 134) points out, the laws derived from the study of human behavior are not laws of perception, cognition, learning, motivation, etc., but laws of behavior. The integration of our present partial theories into an integrative or unitary theory of human behavior is the future task of psychology. Such a theory must be some kind of a phenomenological theory. At any rate, such a theory need not necessarily be a depth theory.⁵

REFERENCES

1. Appel, K. E. Freud and psychiatry. In I. Galdston (Ed.), *Freud and contemporary culture*. New York: International Universities Press, 1957.
2. Blake, R. R., & Ramsey, G. V. (Eds.), *Perception: an approach to personality*. New York: Ronald, 1951.
3. Bronfenbrenner, U. Toward an integrated theory of personality. In

⁵ For some approaches to perceptual theory similar to that taken here, the reader is referred to the symposium edited by Blake and Ramsey (2).

- R. R. Blake & G. V. Ramsey (Eds.), *Perception: an approach to personality*. New York: Ronald, 1951.
4. Bruner, J. S. Personality dynamics and the process of perceiving. In R. R. Blake & G. V. Ramsey (Eds.), *Perception: an approach to personality*. New York: Ronald, 1951.
 5. Cohen, B. D. *et al.* Experimental manipulation of verbal behavior. *J. exper. Psychol.*, 1954, 47:106-110.
 6. Combs, A. W. A phenomenological approach to adjustment theory. *J. abnorm. soc. Psychol.*, 1949, 44:29-35.
 7. Combs, A. W. Counseling as a learning process. *J. counsel. Psychol.*, 1954, 1:31-36.
 8. Cronbach, L. J. Assessment of individual differences. *Ann. Rev. Psychol.*, 1956, 7:173-196.
 9. De Grazia, S. *Errors of psychotherapy*. Garden City, New York: Doubleday, 1952.
 10. Dollard, J., & Miller, N. E. *Personality and psychotherapy*. New York: McGraw-Hill, 1950.
 11. Frenkel-Brunswik, Else. Personality theory and perception. In R. R. Blake & G. V. Ramsey (Eds.), *Perception: an approach to personality*. New York: Ronald, 1951.
 12. Freud, S. *Psychopathology of everyday life*. London: E. Benn, 1949.
 13. Fromm-Reichman, Frieda. *Principles of intensive psychotherapy*. Chicago: University of Chicago Press, 1950.
 14. Gibson, J. J. Theories of perception. In W. Dennis (Ed.), *Current trends in psychological theory*. Pittsburgh: University of Pittsburgh Press, 1951.
 15. Greenspoon, J. The reinforcing effect of two spoken sounds on the frequency of two responses. *Amer. J. Psychol.*, 1955, 68:409-416.
 16. Hildum, D. C., & Brown, R. W. Verbal reinforcement and interviewer bias. *J. abnorm. soc. Psychol.*, 1956, 53:108-111.
 17. Kelly, G. A. *The psychology of personal constructs*. Vol. I: *A theory of personality*. Vol. II: *Clinical diagnosis and therapy*. New York: Norton, 1955.
 18. Klein, G. S. The personal world through perception. In R. R. Blake & G. V. Ramsey (Eds.), *Perception: an approach to personality*. New York: Ronald, 1951.
 19. Krech, D. Cognition and motivation in psychological theory. In W. Dennis (Ed.), *Current trends in psychological theory*. Pittsburgh: University of Pittsburgh Press, 1951.
 20. Lewin, K. *Dynamic theory of personality*. New York: McGraw-Hill, 1935.
 21. Lewin, K. *Principles of topological psychology*. New York: McGraw-Hill, 1936.

22. Lewin, K. Defining the "field at a given time." *Psychol. Rev.*, 1943, 50:292-310.
23. Lindsley, O. R. Operant conditioning methods applied to research in chronic schizophrenia. *Psychiat. Res. Reports No. 5: Research techniques in schizophrenia*. Washington, D.C.: Amer. Psychiat. Ass., 1956.
24. Magaret, Ann. Generalization in successful psychotherapy. *J. consult. Psychol.*, 1950, 44:64-70.
25. Maier, N. R. F. *Frustration: a study of behavior without a goal*. New York: McGraw-Hill, 1949.
26. Mandler, G., & Kaplan, W. K. Subjective evaluation and reinforcing effects of a verbal stimulus. *Science*, 1956, 124:582-583.
27. McCulloch, W. S. Brain and behavior. In W. Dennis (Ed.), *Current trends in psychological theory*. Pittsburgh: University of Pittsburgh Press, 1951.
28. Murphy, G., Murphy, Lois B., & Newcomb, T. M. *Experimental social psychology*. Rev. ed. New York: Harper, 1937.
29. Murphy, G. *Personality: a biosocial approach to origins and structure*. New York: Harper, 1947.
30. Murphy, G. The current impact of Freud upon psychology. *Amer. Psychologist*, 1956, 11:663-672.
31. Oberndorf, C. P. Factors in psychoanalytic therapy. *Amer. J. Psychiat.*, 1942, 98:750-756.
32. Penfield, W. The twenty-ninth Mandsley lecture: The role of the cortex in certain psychological phenomena. *J. ment. Sci.*, 1955, 101:451-465.
33. Phillips, E. L. *Psychotherapy: a modern theory and practice*. New York: Prentice-Hall, 1956.
34. Postman, L. Review of *Nebraska Symposium on Motivation*. Lincoln: University of Nebraska Press, 1955. *Contemp. Psychol.*, 1956, 1:229-230.
35. Rogers, C. R. Some observations on the organization of personality. *Amer. Psychologist*, 1947, 2:358-368.
36. Rogers, C. R. Perceptual reorganization in client-centered therapy. In R. R. Blake & G. V. Ramsey (Eds.), *Perception: an approach to personality*. New York: Ronald, 1951.
37. Rogers, C. R. Client-centered theory. (Behavior theories and a counseling case: a symposium). *J. counsel. Psychol.*, 1956, 31:115-120.
38. Rogers, C. R. The characteristics of a helping relationship. *Personnel & Guid. J.*, 1958, 37:6-16.
39. Shaw, F. J. A stimulus-response analysis of repression and insight in psychotherapy. *Psychol. Rev.*, 1946, 53:36-42.

40. Shaw, F. J. Some postulates concerning psychotherapy. *J. consult. Psychol.*, 1948, 12:426-431.
41. Shaw, F. J. Counseling from the standpoint of an "interactive conceptualist." *J. counsel. Psychol.*, 1954, 1:36-42.
42. Shoben, E. J., Jr. Psychotherapy as a problem in learning theory. *Psychol. Bull.*, 1949, 46:366-392.
43. Shoben, E. J., Jr. Some observations on psychotherapy and the learning process. In O. H. Mowrer (Ed.), *Psychotherapy: theory and research*. New York: Ronald, 1953.
44. Shoben, E. J., Jr. A theoretical approach to psychotherapy as personality modification. *Harvard educ. Rev.*, 1953, 23:128-142.
45. Shoben, E. J., Jr. Counseling and the learning of integrative behavior. *J. counsel. Psychol.*, 1954, 1:42-48.
46. Skinner, B. F. What is psychotic behavior? In *Theory and treatment of the psychoses: some newer aspects*. St. Louis: Washington University Press, 1956.
47. Smith, M. B. The phenomenological approach in personality theory: some critical remarks. *J. abnorm. soc. Psychol.*, 1950, 45:516-522.
48. Smith, M. B., Bruner, J. S., & White, R. W. *Opinions and personality*. New York: Wiley, 1956.
49. Snygg, D., & Combs, A. W. *Individual behavior*. New York: Harper, 1949.
50. Snygg, D., & Combs, A. W. The phenomenological approach and the problem of "unconscious" behavior: a reply to Dr. Smith. *J. abnorm. soc. Psychol.*, 1950, 45:523-528.
51. Verplanck, W. S. The control of the content of conversation: reinforcement of statements of opinion. *J. abnorm. soc. Psychol.*, 1955, 51:668-676.
52. Verplanck, W. S. The operant conditioning of human motor behavior. *Psychol. Bull.*, 1956, 53:70-83.
53. Whyte, W. H. *The organization man*. New York: Simon & Schuster, 1956.
54. Wilson, W. C., & Verplanck, W. S. Some observations on the reinforcement of verbal operants. *Amer. J. Psychol.*, 1956, 69:448-451.
55. Wyatt, F. Climate of opinion and methods of readjustment. *Amer. Psychologist*, 1956, 11:537-542.

CHAPTER 12

Psychotherapy: Art or Science?

The question posed by the title to this chapter is one which has been bothering psychotherapists for some time. With the high prestige of science in our society, the desire of psychotherapists to be identified with a scientific activity is understandable. On the other hand, the state of scientific knowledge in the area of human behavior and human relations has been, and is, such that there is relatively little scientific knowledge about psychotherapy. Thus, some have insisted that psychotherapy is, and must be, an art. There are others who agree that at present psychotherapy is an art, but that it is amenable to scientific investigation, and thus capable of becoming scientific. There is a difference of opinion as to whether the therapist can at one and the same time be a therapist and a scientist. This chapter will consider these various viewpoints and attempt to reach some conclusion about the scientific status of psychotherapy and the therapist.

PSYCHOTHERAPY AS AN ART

Freud, in discussing the attitude of the psychoanalyst, wrote as follows:

All conscious exertion is to be withheld from the capacity for attention and one's "unconscious memory" is to be given full play; or to express it

in terms of technique, pure and simple: One has simply to listen and not to trouble to keep in mind anything in particular. . . . It is not a good thing to formulate a case scientifically while treatment is proceeding, to reconstruct its development, anticipate its progress, and take notes from time to time of the condition at the moment, as scientific interests would require. Cases which are thus destined at the start to scientific purposes and treated accordingly suffer in consequence; while the most successful cases are those in which one proceeds, as it were, aimlessly, and allows oneself to be overtaken by any surprises, always presenting to them an open mind, free from any expectations (5, pp. 324-327).

While it appears that Freud did not always adhere to this advice, it seems to have been accepted as the model by psychoanalysis. Alexander and French summarize the general attitude of psychoanalysts in their statement that "It is admitted that psychotherapy is still more an art, requiring a constant intuitive response to the patient, than it is an exact science" (1, p. iii). A recent exposition of this point of view is found in Reik's *Listening with the Third Ear*, in which he says that "only when he [the therapist] is ready to drop all speculation while he analyzes will he be able to catch the emotional undertones in what his patient says. He should not 'argue' the case like a lawyer, but face it spontaneously and without preconceived ideas" (11, p. 116). Such an approach to psychotherapy is unstructured, unplanned, and unsystematic or not based on logical analysis. As Freud wrote in his autobiographical study, "It is left to the patient in all essentials to determine the course of analysis and the arrangement of the material; any systematic handling of particular symptoms or complexes becomes impossible" (6, p. 74).

Fisher (4) presents in dialogue form arguments for this point of view, along with rebuttals for a more manipulative approach. It is argued that "each patient is a novel experience and a novel problem," that "situations in therapy, as in life, are never repeated exactly." Thus "an analyst needs to be . . . willing to undergo the experience of analysis" with his patient. "But for the analyst to try to be different and masterful is false and alien to therapy. In

my opinion, some analysts get obsessed with the techniques of analysis, *just* at the point when they have lost the courage to develop along with their patients. Psychoanalysis, as a manipulative technology, is not without value to patients. But I see analysis as something more, a genuine experiment in human relations in which the creative potentialities of both participants are evoked."

Rogers (13) has expressed a very similar concept of psychotherapy. He points out that as a therapist he enters the relationship "not as a scientist, not as a physician who can accurately diagnose and cure, but as a person, entering into a personal relationship . . . not consciously responding in a planful or analytic way, but simply in an unreflective way to the other individual . . . I am often aware of the fact that I do not *know*, cognitively, where this immediate relationship is leading." Every such therapeutic relationship is new. Wolstein notes that "Thus we are always involved with new and independent variables and we are constantly confronted with some unpredictable factors in the open future of human existence" (22, p. 183). And Bateson points out that ". . . Interaction sequences always and necessarily contain an element of unpredictability for the participants. At a given instant the individual does not yet have the information which he will have later when the effect of his action becomes observable. Any predictions which he may make about his own later actions must therefore contain an element of guesswork. If he is rigidly bound by his own guesses to the extent, for example, of ignoring the later information, the larger system of which he is only a part will be rigid and incapable of self-correction" (16, p. 287).

PSYCHOTHERAPY AS A SCIENCE

The point of view just described is opposed by some therapists, who condemn it as intuitive, unsystematic, and unscientific. The aims of science, it is pointed out, are understanding, prediction, and control. If psychotherapy is to be scientific, it is argued, then it must go beyond understanding to include prediction and control

of client behavior. The desire to be scientific appears to be strong in many of those engaging in psychotherapy, and results in an approach which, in order to meet the apparent requirements of science, goes beyond understanding to planning and controlling the therapeutic relationship. This influence of a "scientific" attitude on psychotherapy, resulting in a manipulative psychotherapy, was referred to in Chapter 6. Bateson says that "The quantifiable and processal aspects of social interaction predominate in American psychiatry, a tendency which is reflected in such procedures as the plan for therapy which states predetermined goals and predetermined estimates of time" (16, p. 148). Perhaps the greatest extreme of the scientific point of view is expressed by Alexander and French (1).

In the "scientific" approach there is much concern with planning, control, and manipulation of the therapeutic relationship in order to achieve specific desired results in terms of client reaction and behavior. As the protagonist of this point of view in Fisher's dialogue puts it, ". . . as an analyst you have to know what you're doing and where you're going. . . . If you don't know what you're doing, how can the patient be helped? . . . The analyst has to be several steps ahead of his patient" (4). These therapists see the other approach as "fumbling," or "muddling through," a method in which "anything goes," with the analysis proceeding by impulse.

Wolstein, on the other hand, critically describes the controlled approach as follows: "The other analytic approach is to have a definite conception of what ails the patient from the very outset or from the presented history and difficulties. But when followed rigidly, this procedure is fraught with the danger of blinding the analyst" (22, p. 149).

Two major questions may be raised about the scientific approach. The first is whether it is possible to operate in this way on the basis of our knowledge of human behavior. The second is whether it is desirable.

While the artistic or intuitive therapists have been charged with not knowing what they are doing, it appears that the same charge could be made against those who claim to be more scientific in their therapy. Although it may not be expedient to admit it in the face of the increasing prestige of psychology, we are actually unable to predict or to control human behavior to any appreciable extent outside of the laboratory. As one of Fisher's discussants puts it, "Much has been written about personality, but I don't agree that we have a stable body of knowledge. What we have is a great variety of formulations, many of which are provocative but most of which are true mainly for the person who has voiced them. I don't deny that we have some knowledge about behavior which has been derived by scientific experiment. But these research results are not very illuminating for understanding and working with human beings. Controlled experimentation with human behavior is not readily useful in psychotherapy. In short, as analysts we operate more in the dark than you suggest" (4).

We possess no sufficiently reliable or valid knowledge to justify intervention in the lives of other individuals except in limited situations. Few generalizations can be made about human behavior, or even about particular groups of individuals. Statements such as "These individuals, or groups, such as schizophrenics, college students, etc., show this behavior," are in general not possible. There is very little agreement among studies of such groups beyond the most general characteristics. Most therapists' statements beginning "We know . . ." are not supported by any research evidence. "By the most effective methods of objective psychology we are still unable to predict what an individual will do except in terms of central tendencies. . . . If we cannot predict results we cannot prescribe treatment . . . the predictions of individual behavior made by objective principles are very inaccurate" (20, p. 336). If we desired to do so, intervention in or manipulation of the behavior of others would be relatively unsuccessful in view of what the Pepinskys (9, p. 7) call "our discon-

certing ignorance about human behavior." Snygg and Combs (20, ch. XIII) discuss the tremendous amount of knowledge required for responsible therapeutic manipulation of a client. Without this information and knowledge, "treatment becomes no more than stabbing in the dark" (20, p. 290). We could not, if we would, base a manipulative psychotherapy on research evidence. A panel of the American Psychoanalytic Association (7) considered the problems involved in the so-called "planning of the therapeutic campaign," and directed criticism at the brief analytic therapy of the Chicago group (cf. 1). Johnson (7) stated that many members of the group felt that "a great deal of the judgment that enters into diagnostic formulations and decisions about what might be best for the patient in the matter of aim and goals is so subject to the personal factor of the physician that we, at present, are far from any truly objective measure."

With an admitted lack of knowledge upon which to operate, such manipulative procedures would appear to encourage irresponsible if not unethical activities on the part of the therapist. The danger in use of such an approach is recognized by the Pepinskys: "Every counselor tends to construct a hypothetical client who is made to behave as if its behavior followed from assumptions held by the counselor. Unless the counselor can view these assumptions as tentative, can specify their relationships, and can state explicitly the hypotheses which follow, and how observable behavior of the client will confirm or deny these, he may fall victim to his own bias" (9, p. 198). But "Even if such blunders are not involved, nagging questions arise as to how the counselor is to judge when he has sufficiently reliable data to justify his drawing an inference, or when his hunch has been put to a test adequate enough to support acceptance or rejection of its validity. Sad to relate, to these questions we have no simple or final answers" (9, p. 161). It would thus appear that therapists who do attempt manipulation of their clients are therefore not being

scientific, or perhaps even ethical, in view of our scientific knowledge about human behavior.

Although some therapists admit that *at present* we are unable to apply scientific knowledge in psychotherapy, it is stressed that this does not mean that psychotherapy is and must remain an art. The practice of psychotherapy is based upon experience (18), and is not intuitive in some mystical sense. Experience is capable of being analyzed and refined, on the basis of further experience or the controlled experience of the scientific experiment. Psychotherapy is thus potentially scientific, in terms of manipulation and control. "Psychotherapy," say Alexander and French, "becomes a scientific practice when it replaces intuitive knowledge with well established principles of psychodynamics" (1, p. viii).

It appears that the behavior of the client can be controlled by the therapist to some extent, and that as research progresses this control may be extended. In this respect the psychotherapist may be able to control and manipulate the client in a more rational way than at present, so that psychotherapy may thus be considered to be more "scientific." But the matter of control in relation to human beings involves ethical or moral issues. There are many therapists who would reject a psychotherapy involving manipulation and control of clients on an ethical basis. This ethical issue of control was discussed in Chapter 6, and will therefore not be considered here.

THE DILEMMA

There are thus two points of view regarding the manner in which the therapist should function. One is that he is, and should be, a practitioner, interested only in the individual client, working with the client in a unique relationship. The other is that the therapist is a scientist, and that the therapeutic relationship is a field for research in human behavior. Psychoanalysis, for example, is claimed to be a scientific method as well as a therapeutic method; Freud toward the end of his life, becoming pessimistic about the

results of psychotherapy, saw the greatest value of psychoanalysis as a method of studying human behavior.

Bateson compares these two points of view well:

Psychiatry—and this includes not only theories but also the operations of the therapist—is apparently evolving slowly in two directions, one which we call humanistic and one which we call circularistic, for lack of a better term. . . . If he favors the humanistic trend, the psychiatrist will be content with a rather slight understanding of the operational steps and codification of his own thought. He will then test the validity of his synthesis and of his therapeutic operations as an artist might, against his own emotional integrity. If, on the other hand, he is a circularist, he will strive for total articulacy and test his synthesis by the criteria of logical coherence and factual prediction. Moreover, this contrast defines a dilemma which is real in the sense that each of the conflicting views offers certain advantages which must be lost by a too close adherence to the opposing view. The humanist will certainly have the advantage in the actual therapeutic session because he is free to respond swiftly and smoothly as a human being facing his patient in shared humanity. . . . The humanist, like the artist, can act spontaneously out of his own integrity, and need not always stop to determine what he is saying.

On the other hand, the humanist will never create a cumulative science, for he cannot clearly transmit his wisdom to his successors. In so far as psychiatry remains an art, it will build up no body of growing and testable hypotheses (16, pp. 270–271).

Are these points of view irreconcilable? Must psychotherapy be either an art, avoiding prediction and control in order to provide for the optimum development of the unique individual, or a science involving manipulation and control of the client?

SOME SUGGESTED SOLUTIONS

There are those who feel that the dilemma is not insoluble. Various suggestions are made to reconcile practice with the unique client with scientific activity and respectability.

One approach suggests that the therapist should be at one and the same time both a practitioner and a scientist. He is encouraged to be a combination of participant and observer, or a participant observer. Strupp (21) takes this point of view. Perlman suggests a combination of the objective and subjective points of view:

" 'Understanding' involves that seemingly paradoxical response that combines emotional sensitivity with objective appraisal, that joins the ability to feel with a person to that of thinking knowledgeably about him. More, it entails being able to see and hear beneath the surface speech and mannerisms, in order to know what a person is meaning to convey or to cloak" (10, p. 140).

The Pepinskys devote a whole book to the proposition that the therapist can be, and should be, at one and the same time both a practitioner and a scientist while working with a client. They see the therapist as constantly setting up hypotheses which he then tests out in the counseling situation, often by manipulating the client or the situation. "In sometimes a naive, and sometimes a sophisticated manner, he makes predictions about the behavior of his clients and tests them against independent or subsequent observation" (9, p. 166).

The history of psychotherapy is witness to the inability of therapists to be objective observers or scientists. We see what we wish to see in our clients; our hypotheses determine our perception all too frequently. We are easily blinded by hypotheses which are emotionally charged, as hypotheses in psychotherapy are quite likely to be. And it is not impossible that we can and will make our predictions come true. Wolstein notes that ". . . the manner of introducing predictive hypotheses is decidedly more complicated in interpersonal relations than in physics or chemistry, for the authority of the therapist may overwhelm the patient to the extent that he will do what was 'predicted'; the boundary line between prediction and suggestion, which is entirely irrelevant in natural science, is so difficult to maintain in social science" (22, p. 49).

Traditionally, science requires using an external frame of reference. Psychotherapy, on the other hand, involves, according to many therapists, use of an internal frame of reference. The roles are thus incompatible. As a participant, the therapist is biased in his observations. On the other hand, as an observer, the therapist is handicapped in achieving empathy and understanding. Concen-

tration on attempting to analyze, set up hypotheses, and make predictions interferes with developing a nonevaluative therapeutic relationship. It is probably humanly impossible for the therapist to play both roles at the same time. The roles are incompatible. As was suggested in Chapter 10, when the therapist takes an external frame of reference for the purpose of evaluation, he is then not a therapist. Berenda expresses this conflict as follows: "When the clinician is engaged most deeply and effectively in the therapeutic situation, he should be empathizing in free association with his client. A compassionate warmth must pervade the therapeutic relation so far as the therapist is concerned. During these moments, the taking of a note, or the writing of a report in a brief sentence, will break the therapeutic relationship or at least reduce its intimacy and therapeutic effectiveness" (3).

The Pepinskys recognize some other difficulties involved in regarding therapy as a scientific study. Generalization, which is an objective of science, is impossible from a single case. "It is a seeming paradox that the more accurate and precise are our descriptions of a single case, the less we are able to generalize to any other case. Conversely, the more we extend our statements to group description, the less likely we are to account for the idiosyncrasies of the individual" (9, p. 168). Also, they write, the counselor's "clinical predictions, formulated within the confines of a single case, are not, of course, predictions in the statistical sense. But they may be an important link in the chain of observation and inference that can lead to verifiable predictions that are both clinical and statistical. Out of his unrepeatable experience with single cases the counselor can derive hypotheses to be tested in controlled experimentation involving many cases" (9, p. 167). In other words, the kind of activity of the counselor proposed by the Pepinskys is actually not scientific study, but is the source of hypotheses for such study. It is not necessary, however, that the therapist function as they suggest for him to develop such hypotheses.

It is not necessary that, to be considered scientific, the therapeutic interview be conducted as a research experiment. Although the psychotherapist may not engage in actual scientific investigation during the therapeutic process, psychotherapy may be considered as scientific activity. The application of scientific knowledge to the counseling process is applied science. Such knowledge is not limited to specific manipulation of client behavior.

Manipulation is not necessary to produce change. Change is made possible by providing opportunities for the individual to restructure his perceptions. The history of the human race is one of adaptation to, or restructuring of, its environment, of learning to solve the problems of survival. The basic required condition is freedom from extreme stress or threat. Individuals still possess this ability to adapt or restructure when they are provided with the appropriate environment.

The Pepinskys (9, p. 12), to include client-centered therapists within the field of science, suggest that the client-centered counselor "manipulates" and thus controls by creating a counseling situation in which certain kinds of client behavior may develop. In this sense all therapy is controlled, and, in so far as the resulting behavior is predictably related to the conditions of psychotherapy, psychotherapy is scientific. The process of psychotherapy, as Rogers (12, chs. 4, 13, 14) has repeatedly pointed out, is predictable, and thus scientific.

While it is thus possible to admit psychotherapy as a process to the field of science, it is only in a very broad sense that it is predictable and controllable. In this broad area, it would appear that we can be scientific to the extent of saying, "If we create this kind of therapeutic situation, including such and such conditions, then the client will react in such and such a way." To go further, and to introduce specific manipulations into therapeutic activity—if this were desirable in terms of one's philosophy of the counsel-

ing relationship and goals—appears to be impossible in our present state of knowledge.

If it be claimed that these principles have not been verified but are only hypotheses, such psychotherapy may still be scientific in the sense that it is a testing of the hypotheses. The data obtained during psychotherapy, by the use of sound recordings or sound motion pictures, may be used for research. It is also possible for the therapist to test, by his total approach to psychotherapy, a hypothesis. In this sense the client-centered therapist is constantly testing the hypothesis that client-centered therapy is effective. But this requires the application of a known, defined, controlled approach in a consistent manner. This is not the case in the approach suggested by the Pepinskys. In the former instance, data on a number of clients can be analyzed for results, or effects. In the latter case, with constantly varying conditions, *the data cannot be studied scientifically*. There is actually no controlled or experimental check on the hypotheses or predictions of the therapist.

Rogers (13) has been concerned with the apparent conflict between the practice of psychotherapy as an art (what he terms the experiential viewpoint), and the methods and concepts of science. He describes the commonly accepted scientific viewpoint. Science, rather than being concerned with the individual relationships, is interested in abstractions and generalizations regarding therapy. "It can give us a more exact description of the events of therapy and the changes which take place. It can begin to formulate some tentative laws of the dynamics of human relationships. It can offer public and replicable statements, that if certain operationally definable conditions exist in the therapist or in the relationships, then certain client behaviors may be expected with a known degree of probability." But "The scientific description of therapy and therapeutic relationships would become increasingly *unlike* those phenomena as they are experienced" (13).

Rogers marshals the scientists' questions regarding the experiential viewpoint: How do you know that the relationship is real,

or true? Doesn't this approach prevent the improving of therapeutic skill? Doesn't this approach imply that there are elements in it which cannot be predicted? Doesn't this method challenge or discard the one method which has resulted in the advance of knowledge?

On the other hand, the experientialist has some questions. Rogers points out that science always deals with objects, and makes everything with which it deals an object. If people become objects, knowledge about them seems to lead to manipulation, to control. Doesn't this raise the question of whether ethics is a more basic consideration than science?

These views, then, do seem to be irreconcilable. Rogers, however, believes that this is because of an error in the perception or description of science.¹ Manipulative control is not a necessary part of science. As MacLeod says, "The goal of science as science is not prediction and control, but understanding. Prediction is merely the test of understanding and control the practical reward" (8). Control is not possible in some sciences, such as astronomy. Rogers notes that "Science may also give the possibility of increased prediction and control . . . , but this is not a necessary outcome of scientific endeavor" (13). Control as a goal is a value which lies outside of science. Freedom, independence, self-actualization, are also goals which are outside of science. Science provides the methods or means to achieve these goals, and the understanding provided by science can be used to achieve them.

Rather than science being a body of tentatively verified knowledge or fact, collected by an impersonal methodology, Rogers suggests that "science exists only in people." The beginnings of science lie in the immersion of the individual in experiences in an area in which he is interested, which he senses and "lives" subjectively, and out of which he develops a hypothesis, which is

¹ Bakan (2) notes that "When . . . the process of observation forces us towards a view that there exists a realm of phenomena for which the scientific approach is inappropriate, then we must conclude that the inappropriateness is inherent in that which we conceive science to be."

a tentative faith. Then scientific methodology is used as a way to determine the reality of the hypothesis, a method of avoiding self-deception. The techniques and methods of science exist then, "not for themselves but as servants in the attempt to check the subjective feeling or hunch or hypothesis of a person with objective fact." The findings of science do not exist as a body of knowledge. "Actually there is no such body of knowledge. There are only tentative beliefs, existing subjectively, in a number of different persons. If these beliefs are not tentative then what exists is dogma, not science" (13). Or again, "Science involves taking an external frame of reference, in which we check our hypotheses basically through empathic inferences as to the internal frame of reference of our colleagues. They perform the same operations we have (either actually or through symbolic representation), and if they perceive the same events and meanings, then we regard our hypotheses as confirmed" (14, p. 39a). The uses to which we put science are also, as are its origin, process, and conclusions, subjective.

Science, then, is not something outside of people. "It is one phase of subjective living" (13). If the subjective, experiential sources of hunches and hypotheses is a part of science, then psychotherapy is science. The therapist can be a scientist by being a therapist only, though this is not all of science. As a result of his experience as a therapist and his observations and abstractions of these experiences, hypotheses may be formed, which are then tested by accepted scientific methods. As Smith, Bruner, and White put it: "In the development of a science there is a strategy of discovery as well as a strategy of proof. In envy of the precision of method and theory attained by the physical scientists, psychologists and social scientists have in recent years focussed their efforts perhaps too exclusively in the direction of proof" (19, p. v).

The therapist is thus a scientist in the sense that he is engaged in an experience which, even when it is not the application of existing scientific knowledge or the experimental analysis of the

process of psychotherapy, is the source of hypotheses for further scientific analysis. Both for the fostering of the development of such hypotheses, and for the psychotherapeutic process itself, the internal rather than the external frame of reference is desirable. For in order to understand human behavior scientifically as well as therapeutically, whether in or outside the therapeutic relationship, it is necessary to study it from the internal frame of reference.² Observation and description from the "objective" or external frame of reference may be possible and have some value and use in certain situations. But perhaps the paucity of knowledge about human behavior is a result of the limitations inherent in this point of view. Human behavior is, as has been pointed out in earlier chapters, determined by the phenomenological field of the behavior. It is only through the study of this field that we will be able to understand human behavior. Bakan (2) suggests that, "unless the experience of the other is accepted as a reality, neither clinical success nor theoretical progress along these lines can be made." The objective study of behavior from this frame of reference is as scientific as the study of behavior from an external frame of reference.

REFERENCES

1. Alexander, F., & French, T. M. *Psychoanalytic therapy*. New York: Ronald, 1946.
2. Bakan, D. Clinical psychology and logic. *Amer. Psychologist*, 1956, 11:665-662.
3. Berenda, C. W. Is clinical psychology a science? *Amer. Psychologist*, 1957, 12:725-729.
4. Fisher, K. A. Psychoanalysis: art or system? *J. psychoanalytic Psychol.*, 1953, 1(4):54-69.
5. Freud, S. Recommendations for physicians on the psychoanalytic method of treatment. In *Collected papers*. Vol. II. London: Hogarth Press, 1925.

² The statement of Tolman (E. C. Tolman, The determiners of behavior at a choice point. *Psychol. Rev.*, 1938, 45:1-41), quoted by Bakan (2), on the prediction of behavior in rats is pertinent here: "But, in any case, I, in my future work, intend to go ahead imagining how, *if I were a rat*, I would behave as a result of such and such an appetite and such and such a degree of differentiation; and so on."

6. Freud, S. *An autobiographical study*. London: Hogarth Press, 1936.
7. Johnson, Adelaide, & English, O. S. The essentials of psychotherapy as viewed by the psychoanalyst. *J. Amer. psychoanalytic Ass.*, 1953, 1:550-556.
8. MacLeod, R. B. The phenomenological approach to social psychology. *Psychol. Rev.*, 1947, 54:193-210.
9. Pepinsky, H. B., & Pepinsky, Pauline N. *Counseling theory and practice*. New York: Ronald, 1954.
10. Perlman, Helen. *Social casework: a problem-solving process*. Chicago: University of Chicago Press, 1957.
11. Reik, T. *Listening with the third ear*. New York: Farrar, Straus, 1948.
12. Rogers, C. R. *Client-centered therapy*. Boston: Houghton Mifflin, 1951.
13. Rogers, C. R. Persons or science? A philosophical question. *Amer. Psychologist*, 1955, 10:267-278.
14. Rogers, C. R. *A theory of therapy, personality, and interpersonal relationships, as developed in the client-centered framework*. Chicago, 1956. (Mimeographed.)
15. Rogers, C. R. A process conception of psychotherapy. *Amer. Psychologist*, 1958, 13:142-149.
16. Ruesch, J., & Bateson, G. *Communication: the social matrix of psychiatry*. New York: Norton, 1951.
17. Sarbin, T. R. Clinical psychology—art or science. *Psychometrika*, 1941, 6:391-400. Also in A. H. Brayfield (Ed.), *Readings in modern methods of counseling*. New York: Appleton-Century-Crofts, 1950.
18. Shoben, E. J., Jr. Some observations on psychotherapy and the learning process. In O. H. Mowrer (Ed.), *Psychotherapy: theory and research*. New York: Ronald, 1953.
19. Smith, M. B., Bruner, J. S., & White, R. W. *Opinions and personality*. New York: Wiley, 1956.
20. Snygg, D., & Combs, A. W. *Individual behavior*. New York: Harper, 1949.
21. Strupp, H. H., et al. Comments on Rogers' "Persons or science." *Amer. Psychologist*, 1956, 11:153-157.
22. Wolstein, B. *Transference: its meaning and function in psychoanalytic therapy*. New York: Grune & Stratton, 1954.

CHAPTER 13

Common Elements in Psychotherapy: Essence or Placebo?

Many writers have pointed out that all schools of psychotherapy, and all therapists, including Christian Scientists and dianeticists, claim, and apparently achieve, cures or at least changes in behavior (4, 14, 20, 23, 26). Furthermore, as Black and Hathaway (1, 14) point out, success is apparently achieved by some individuals having little or no training in psychotherapy. Collier (4) states that "the fact that all therapies have successes and all therapies have failures strongly suggests that there should be bases of integration." Rosenzweig (20) notes that ". . . it is justifiable to wonder . . . whether the factors that actually are operating in the several different therapies may not have much more in common than have the factors alleged to be operating." Since this is the case, then either there must be common elements in all therapies, or there are different ways of achieving the same results.

Philosophies and techniques of psychotherapy obviously vary tremendously. Nevertheless, there seems to be a strong interest in discovering common elements rather than attributing the results to radically different but equally effective techniques or approaches.

To be sure, there may be questions regarding the definitions of success or the goals of psychotherapy (see Chapter 4). In some

cases success may be little more than symptom relief, a temporary change in behavior, or a momentary feeling of relief or tension reduction in the client. Such changes, or success, may be achieved through techniques or methods which are not appropriate or successful in achieving more acceptable and permanent goals of psychotherapy. Nevertheless, there are enough apparently successful results in terms of acceptable goals, using widely differing techniques, to pose a problem as to whether there are common elements in these techniques and if so what these factors are. Are there some basic similarities among the apparently different methods and approaches to psychotherapy?

There are some, e.g., Eysenck (9), who feel that there is no evidence that any psychotherapy is successful. Eysenck attempts to show that the use of psychotherapy achieves no better results than so-called spontaneous remissions. This argument fails to recognize that there is probably no such thing as a truly spontaneous remission (2); some therapeutic activity must be present, though it may be within the client rather than in his environment. Rosenzweig (21) has adequately replied to Eysenck's critique. While admitting that there is no irrefutable evidence for the effectiveness of psychotherapy, neither is there any good evidence that it is ineffective. Although there is no clear or explicit scientific evidence at present, there appears to be adequate clinical evidence that psychotherapy has *some* effects on *some* clients. These effects need to be accounted for, particularly since they are achieved by so many apparently different methods.

Efforts to identify common elements have been numerous. Some have been limited to very general, or external aspects of the therapeutic process. Rioch (18), for example, points out that all therapies involve an interaction between the therapist and the client, a relationship involving communication. Other writers stress the factor of rapport (1, 15, 26), or transference as common elements. Catharsis or ventilation is felt by some to be a common procedure (20, 26). Collier (4) lists some general, if not universal tech-

niques, processes, and aspects of the therapeutic relationship. But it is not enough to say that all psychotherapies involve an interpersonal relationship based on rapport in which there is communication between the therapist and the client. It is necessary to be more specific, to describe the kind of relationship, the nature and content of rapport and communication.

An analysis of efforts to specify or isolate such common factors or elements in psychotherapy suggests that there are two major points of view. One of these appears to stress a common factor of authority, while the other appears to emphasize understanding, or an accepting, nonthreatening relationship. These approaches appear to be related to the manipulative and understanding points of view in human relations discussed in Chapter 6.

PSYCHOTHERAPY AS AN AUTHORITATIVE INTERPERSONAL RELATIONSHIP

Authority has been seen by many as a common element, even as the major common element, in psychotherapy. The therapist is, and must be, it is argued, an authority figure.

Paradoxically, considering many of the statements of Freud, psychoanalysis historically is an authoritative psychotherapy. Psychoanalysis developed out of hypnosis, which is authoritative in nature, involving active suggestion. With the abandonment of hypnosis, suggestion continued to be an element in the psychoanalytic technique. Suggestion is an element in transference,¹ for example, as well as in interpretation. The transference, as indicated in Chapter 9, is an authority or dependency relationship. Although Freud wanted to avoid the suggestibility of hypnosis, he accepted suggestion in the process of overcoming resistances.²

¹ Wolstein writes: ". . . the authoritarian attitude of the analyst during positive transference was certainly the attitude of the suggestive hypnotist during the trance" (24, p. 112). See also S. Freud, *An Autobiographical Study*. London: Hogarth Press, 1936, pp. 74, 75: "It is perfectly true that psychoanalysis . . . employs the instrument of suggestion (or transference)."

² Wolstein suggests that "Freud's great reliance on the analyst's authority in the treatment situation may be attributed to factors other than his early training in hypnosis; for example, that he was personally an authoritarian" (24, p. 21).

Oberndorf writes as follows regarding this suggestive nature of psychoanalysis:

Freud in his original need to explore the dynamics of mental disorder sought to avoid the term suggestion because it connoted the imposition of the will, the authority of the physician upon the patient. He felt that such domination led to suppression of the patient's reactions which were seeking expression and which above all things he desired to investigate and interpret. Nevertheless he appreciated that the suggestive influence of the physician is "inevitably exercised in psychoanalysis but is diverted on to the task assigned to the patient of overcoming his resistances—i.e., of carrying forward the curative process."³ The difficulty, one may say, the impossibility of limiting suggestion to a single phase of analysis without its overflowing into others seems not to have been noted. Only Ferenczi,⁴ one of the most independent and original thinkers in Freud's earlier entourage, ventured to reflect in 1932 that "the truth cannot be entirely spontaneously discovered—it must be suggested" (16).

While there are wide variations in the techniques of present day analysts, Oberndorf (16) suggests that "Although the word suggestion has been practically obsolete in psychoanalytic literature for the past ten years the entire procedure of psychoanalysis has a suggestive implication." He further states that "The element of suggestion enters subtly but almost invariably into all forms of psychotherapy." Ziskind (26) also feels that suggestion is a common element in all therapy.

Perhaps the most explicit advocate of authority as the essential element in psychotherapy is De Grazia. He writes that "Moral authority, an idea widely spurned by modern healers of the soul, is the crux of psychotherapy. The crystals which remain after distilling the multiplicity of therapies are not many. A bewildering array of brilliants dwindles down to a precious few: neurosis is a moral disorder, the psychotherapeutic relationship is one of authority, the therapist gives moral direction" (6, p. 103).

The bases of authority are found in all therapeutic relationships.

³ S. Freud, Untranslated Freud, *Int. J. Psycho-Anal.*, 1942, 23:104.

⁴ S. Ferenczi, Suggestion in (nach) der Analyse. In *Bausteine zur psychoanalyse*. Bern: Huber, 1939. Vol. IX, p. 282.

The following circumstances, which establish the authoritative nature of the relationship, are to be found in all known psychotherapies. First of all, the patient is in grave need; the therapist is not. . . . The second feature of the psychotherapeutic relationship is that the patient is ignorant whereas the therapist is informed. . . . Here lies buried his independence. . . . The patient expects to be obedient or passive while the psychotherapist is to be active, to tell him what to do, to play the agent to the patient . . . initiative is with the psychotherapist and he is expected to call the tune. Furthermore, the patient believes that disobedience to the therapist carries a penalty. . . . In addition the patient is accessible while the psychotherapist is comparatively inaccessible. . . . Translated into concrete terms, the prestige of the therapist insures that in matters of dress, achievement, language, income, education, taste, or manners the patient generally will feel he is dealing with someone of higher status (6, pp. 44-47).

Authority means "rightful power." "The concept of authority brings together and clarifies the ideas of prestige, status, and suggestion" (6, p. 61).

Authoritative methods of therapy include hypnosis, suggestion, reassurance, persuasion, advice, guidance, direction, and manipulation. In addition to these specific techniques, however, there are subtle effects of an authoritative attitude or role. The authoritative role is not necessarily intentionally assumed by the therapist—it is assigned to him by the client. The status of the psychotherapist is, as pointed out in Chapter 5, usually higher than that of the client. He is a professional person, and as suggested, there is a tendency for the client to assume a dependency status. This tendency facilitates the development of a transference relationship (see Chapter 9). The tendency of the client to accept the therapist as a model was mentioned in our discussion of values in psychotherapy (Chapter 4). The concept of rapport sometimes includes an element of authority (26) or dependency, or more often it is stated as the development of "confidence in the doctor" or therapist.

The therapist is thus assigned a superior status by the client. Black (1) suggests that this status factor is often overlooked, and that "occasionally someone is so naive as to deny its existence."

While it is no doubt true that there is a status or authority

element in all, or at least most, therapeutic relationships, the degree varies tremendously, depending on whether the therapist fosters or minimizes this aspect of the relationship. Authority is used in different ways in discussions of psychotherapy. In the sense of intrinsic authority based on training and competence or skill, the therapist is an authority. De Grazia (6, p. 42) refers to this concept of authority as power based on esteem or respect. Oppenheimer (17) also uses authority in this respect, as being based on professional prestige, knowledge, and adequate personality adjustment.

But this authority may be minimized or maximized by the therapist; it may be used as an instrument or technique, or avoided. It is maximized, for example, by those therapists who emphasize the trappings or external evidences of professional prestige and success, such as luxurious offices, receptionists, prominent displays of degrees and diplomas, even the wearing of a white coat. And the emphasis of such authority tends to go with the use of the authoritative techniques mentioned above, which require authority for their effectiveness. As Oppenheimer indicates, "The psychologist has to be superior, and his superiority has to be accepted by the client if he is to follow the psychologist's far-reaching suggestions as to changes in the client's life."

In other words, therapists differ in the way in which they use or depend on authority. At one extreme are those who enhance and develop the difference in status and authority between themselves and their clients, who maintain or even attempt to widen the gap, and who use and exploit authority in their techniques. At the other extreme are therapists who attempt to minimize and reduce the status gap and the authority attributed to them by their clients, and avoid using techniques which are dependent on authority for success.

PSYCHOTHERAPY AS AN UNDERSTANDING RELATIONSHIP

Those therapists who reject authority as a necessary element in psychotherapy tend to emphasize understanding as a common ele-

ment. Techniques are directed toward fostering communication and understanding rather than manipulation of the client's attitudes and behavior through suggestion or advice. Efforts are made to reduce, if not eliminate, the authority element. As Estes (8) states it, "The therapist is consistently not an authority figure, at least not any of the kinds of authority figures the client has experienced."

The elements or techniques in this type of relationship were dealt with earlier. A number of writers have suggested that these are common to all counseling and psychotherapy. Different writers use different terminology, but apparently all are talking about the same things. Cottle (5) refers to mutual trust and respect between the counselor and client, a "warm, permissive atmosphere." The client is accepted as a person worthy of respect. There is honesty and frankness in the relationship, which is lacking in threat to the client. Estes (8) uses the word "security" to describe a similar relationship. Black (1) refers to rapport as including "warmth and responsiveness," and the interest of the therapist in the client as a person. Hathaway (15) says that "rapport is one feature common to nearly all types of counseling." Black (1) also lists acceptance as a universal element, defining it as "conveying to the patient that the therapist appreciates his basic human worth regardless of the thoughts, feelings and attitudes—good or bad—which he may express." Wyatt (25) includes acceptance as "a point common to all systems of psychotherapy." Black (1) lists support as a third common factor. By support he does not necessarily mean supportive activity on the part of the therapist, although he does include this. But support may be provided in the relationship as a sheltered atmosphere, or as "a relationship giving support in the sense of giving security and understanding." Such support may be conceived of as the absence of threat, which is an important aspect of the client-centered approach. The essence of the understanding approach is empathic understanding and communication with the client in a nonthreatening situation.

These two concepts of psychotherapy—as an authoritative or as an understanding relationship—appear to be diametrically opposed or mutually exclusive. However, it is possible that they can, to some extent at least, be reconciled. There are three possibilities for doing so. (1) It could be maintained, as suggested above, that there is some element of authority in all therapeutic relationships, and that it is this element which is responsible for any success achieved. This is difficult to support, since there are therapeutic relationships where authority is so successfully minimized as to be of little significance in the relationship. (2) It could be held that, conversely, there is an element of understanding—of interest in and respect for the client—in all therapeutic relationships, even the most authoritarian, and that it is this element which is responsible for success. It seems likely that this is the case in most, if not all, kinds of psychotherapy. The work of Fiedler (10, 11, 12), discussed in Chapter 8, supports this. (3) It is possible that there are two distinct kinds of relationship which are called psychotherapy, one being the authoritative, the other the understanding. However, there are some therapies or therapists who manifest little, if any, of the characteristics of the understanding relationship; in which case, how to account for their success—or apparent success? Perhaps the definitions of success are so wide and varied that they include different kinds of results. The success of authoritarian therapy may be limited, being restricted to symptom removal, solution of immediate problems, temporary relief, etc., and may easily be achieved by hypnosis, suggestion, and reconditioning as practiced, for example, by Salter (22).

Chapter 7 delineated a common element in emotional disturbance. This element was described as the loss of self-esteem. If this is true, then it would appear that successful psychotherapy would require the restoration, or development, of self-esteem. The common element or elements in psychotherapy would then be those which fostered this process. A nonauthoritarian attitude of esteem

and respect for the client, manifested by interest in him as a person and by the attempt to understand him and to communicate this understanding, is the "specific" (26) therapy for this common element in emotional disturbance. For the authoritarian approach to be acceptable, it would be necessary to show that it achieved the same results, or that the loss of self-esteem is not the common element in emotional disturbance, and that there is another common element for which the authoritarian approach is the appropriate method of treatment. De Grazia (6) in effect takes this latter approach. It remains for further research to decide the issue.

THE PLACEBO EFFECT IN PSYCHOTHERAPY

In medicine it is a well-known fact that patients respond to the administration of inert substances such as saline solution or sugar pills, known as placebos. This phenomenon is called the placebo effect (19). In testing new drugs or medications, the existence of this placebo effect makes it necessary that the effectiveness of the new substance or treatment be compared with results achieved with a placebo. The placebo can significantly affect physiological functioning, as well as result in psychological changes.

Since the placebo effect is psychological in nature, it is apparent that it must be considered in the evaluation of the effects of psychotherapy. The basic question is, then, does psychotherapy achieve results beyond the placebo effect? "This effect," as Rosenthal and Frank (19) point out, "may be thought of as a nonspecific form of psychotherapy. . . ."

Rosenthal and Frank suggest that "The similarity of the forces operating in psychotherapy and the placebo effect may account for the high consistency of improvement rates found with various therapies, from that conducted by physicians without training to intensive psychoanalysis" (19). The rates of improvement reported for various forms of psychotherapy are similar to those reported as resulting from the placebo effect in illnesses with

emotional components, i.e., about 60 percent. "To show that a specific form of treatment produces more than a nonspecific placebo effect it must be shown that its effects are stronger, last longer, or are qualitatively different from those produced by the administration of placebos, or that it affects different types of patients . . ." (19).

It appears to be reasonable to argue that the efficacy of psychotherapy is limited to the placebo effect. The review and conclusions of Eysenck (9) would seem to support this view. It is generally accepted that the placebo effect is produced by suggestion, and by an authoritative attitude of the physician—common elements of psychotherapy, according to one point of view. If we argue that these elements are not present in the understanding point of view, we might claim that, inasmuch as about the same degree of success is achieved by each approach, the understanding point of view, in achieving success without the use of authority or suggestion, is more specific. Although some element of authority may be present in the understanding approach, it certainly is at a minimum.

However, in addition to the authoritative-suggestive element in the placebo effect, there is another factor, which is perhaps more important in psychotherapy than in medical treatment. This is the matter of attention, interest, or concern. It has been remarked by numerous observers that mental patients respond to any treatment which involves attention, i.e., it is attention rather than the specific treatment which produces results. Cobb notes, in connection with the use of the new drugs, that "The remarkable improvement reported in many chronic patients may be partly due to the increased attention by the staff and an atmosphere of therapeutic optimism" (3, p. 25). Hathaway suggests that ". . . almost any form of attention given to a patient's problems, whether skilled and upon good theoretical bases or unskilled and poorly conceived, is likely to result in improvement" (15). This is perhaps the effective element in therapeutic results achieved by untrained people. It is the therapy of a good personal relationship.

So, while it can be reasoned that the results of authoritative psychotherapy may be attributed in part to the placebo effect, the same statement can be made with regard to the understanding type of psychotherapy. While the understanding approach may minimize the authoritative or suggestive effect almost to zero, the authoritative approach cannot eliminate or reduce to a negligible degree the factor of interest and attention, since these are essential, and apparently more universal than authority, in psychotherapy. In either case, can it be shown that the effects are greater than could be achieved by the placebo effect alone? While the rates of improvement in various treatment situations (9, 20) would suggest a negative answer, these rates cannot be accepted as comparable, as Rosenzweig (21) has made clear. Although it does not appear to be possible to give a negative answer, neither is it possible to present clearcut evidence for a positive answer. Not only has the severity of disturbance not been studied and controlled, but the criteria of improvement or success have varied tremendously. It might be reasoned, as Rosenzweig (20) implies, that the requirements for improvement have been minimal in situations where the placebo effect has been the main or only operating factor, whereas in situations where other more specific therapeutic elements have entered, the requirements for regarding the treatment successful have been higher. There is no proof of this, however, nor any evidence that there are differences in the duration of the effects.

It is commonly felt that the results from authoritative or suggestive treatment are not as enduring, and are qualitatively different from the results of understanding or "insight" therapy. Freud, for example, abandoned hypnosis partly because of the lack of enduring results and the appearance of new symptoms. The goals of authoritative and understanding therapists may be different, the first group being satisfied with symptom removal, reduction of tension or anxiety, or in general any kind of relief, which may be transitory effects. But, as Rosenthal and Frank state, "We know of no experimental study which demonstrates that

therapeutic effects based on insights or perceptual reorganization . . . are less superficial or less transitory" (19). This is a problem amenable to research, however. Equated groups of clients receiving authoritative and understanding psychotherapy could be compared in terms of the nature and duration of the results in personality and behavior. The theory upon which this book is based would predict that the latter group would show the greater or more significant and enduring results. There might, of course, be some difference of opinion about appropriate criteria. The criterion of responsible independence or increased self-esteem might not be accepted by the authoritarian group. Nevertheless, if differential results were found, therapists could make a choice as to the goals they desired. It might also be the case, however, that if no significant differences were found, many therapists would choose the understanding approach on an ethical or philosophical value basis.

There appear to be two types of placebo effect, one the result of authority and suggestion, the other the result of interest and attention. Both operate to some extent in both approaches to psychotherapy, though it would appear that each approach involves one more than the other. Their influence is not eliminated from the suggested comparative study of authoritative and understanding psychotherapy. Is it possible to eliminate, or control, the placebo effects? Rosenthal and Frank suggest a plan for doing so. However, their plan involves only one type, or source, of placebo effect, which operates through the patient's conviction that therapy will help him. The placebo effects as discussed here are not as direct or as simple as this. If the effects reside in the authority of the therapist, or his interest and attention, they may not, and probably are not, directly proportional to, or the same thing as, the client's confidence that he can be helped. Nor can they be eliminated from psychotherapy completely. While it would be maintained that authority is not essential for psychotherapy, it perhaps cannot be removed entirely from the relationship. On the other hand, interest

and attention are essential. Thus, to study the placebo effect, the influence of interest and attention alone in comparison with interest and attention plus other factors must be evaluated. This raises the problem of defining or delineating interest and attention, separating them from understanding and empathy, from the communication of understanding, etc. If not the essence, interest and attention are part of the essence of psychotherapy. Perhaps it would be possible, however, to perform such an experiment, by using untrained therapists, or therapists trained only to show interest and attention, or trained therapists who restricted themselves to these manifestations in the therapeutic relationship, and comparing the results with therapists engaging in the complete therapeutic relationship. It would be predicted that the results would differ, with the clients being treated with understanding and communication of this understanding showing greater or different results than those given only the interest and attention of the therapist.

If interest and attention are thus universal and essential in psychotherapy, and if they are a source of the placebo effect, are then psychotherapeutic results essentially the placebo effect? While at first glance this would appear to be an unacceptable conclusion, it is probably not as derogatory to psychotherapy as it appears. The placebo effect is a psychological effect, and, in so far as it is related to interest and attention, a desirable effect. It is perhaps, as has been suggested above, difficult to divorce from understanding and communication. One who is genuinely attentive to and interested in another person no doubt understands and communicates this understanding, as well as his interest, to the other. The interest and attention constitute an aspect of the lack of threat that is essential for therapeutic personality change.

CONCLUSION

In this chapter we have attempted to determine the common elements in psychotherapy. Two such elements appear to be sug-

gested in the literature. These elements, designated as authority and understanding, seem to be somewhat inconsistent with each other. They parallel the two approaches to human relations discussed earlier (Chapter 6). While both are probably present to some extent in all therapeutic relationships, it appears that authority may be maximized in one type of relationship, while in another understanding may be maximized and authority minimized.

These elements are related to the placebo effect in psychotherapy. The placebo effect consists of two aspects, one related to authority and the other to interest and attention. While interest and attention may thus be considered as sources of the placebo effect, they are not therefore to be rejected or eliminated from psychotherapy. As psychological factors, interest and attention are basic characteristics of all good human relationships, and so are a necessary part of the therapeutic relationship.

It is suggested that the results of a highly authoritarian psychotherapy are essentially due to the placebo effect. On the other hand, the results of an understanding psychotherapy, while including those due to the placebo effect of interest and attention, go beyond this to include results related to deep understanding and the communication of this understanding. It is suggested that authority is neither a necessary nor a desirable condition of psychotherapy, while understanding is necessary to achieve results beyond the placebo effect.

REFERENCES

1. Black, J. D. Common factors of the patient-therapist relationship in diverse psychotherapies. *J. clin. Psychol.*, 1952, 8:302-306.
2. Cartwright, D. S. Effectiveness of psychotherapy: a critique of the spontaneous remission argument. *J. counsel. Psychol.*, 1955, 2:290-296.
3. Cobb, S. Contemporary problems in psychiatry. In *Theory and treatment of the psychoses: some newer aspects*. St. Louis: Washington University Press, 1956.
4. Collier, R. M. A basis for integration rather than fragmentation in psychotherapy. *J. consult. Psychol.*, 1950, 14:199-205.

5. Cottle, W. C. Some common elements in counseling. *Personnel Guid. J.*, 1953, 32:4-8.
6. De Grazia, S. *Errors of psychotherapy*. Garden City, New York: Doubleday, 1952.
7. Dymond, Rosalind F. Adjustment changes in the absence of psychotherapy. *J. consult. Psychol.*, 1955, 19:103-107.
8. Estes, S. G. Concerning the therapeutic relationship in the dynamics of cure. *J. consult. Psychol.*, 1948, 12:76-81.
9. Eysenck, H. J. The effects of psychotherapy: an evaluation. *J. consult. Psychol.*, 1952, 16:319-324.
10. Fiedler, F. E. The concept of an ideal therapeutic relationship. *J. consult. Psychol.*, 1950, 14:235-245.
11. Fiedler, F. E. A comparison of therapeutic relationships in psychoanalytic, nondirective and Adlerian therapy. *J. consult. Psychol.*, 1950, 14:436-445.
12. Fiedler, F. E. Factor analyses of psychoanalytic, nondirective, and Adlerian therapeutic relationships. *J. consult. Psychol.*, 1951, 15:32-38.
13. Grummon, D. L. Personality changes as a function of time in persons motivated for psychotherapy. In C. R. Rogers & Rosalind F. Dymond (Eds.), *Psychotherapy and personality change*. Chicago: University of Chicago Press, 1954.
14. Hathaway, S. R. Psychotherapy and counseling: summary of discussion. *J. consult. Psychol.*, 1948, 12:90-91.
15. Hathaway, S. R. Some considerations relative to nondirective counseling as therapy. *J. clin. Psychol.*, 1948, 4:226-231.
16. Oberndorf, C. P. Constant elements in psychotherapy. *Psychoanalytic Quart.*, 1946, 15:435-449.
17. Oppenheimer, O. Some counseling theory: objectivity and subjectivity. *J. counsel. Psychol.*, 1954, 3:184-187.
18. Rioch, D. McK. Theories of psychotherapy. In W. Dennis (Ed.), *Current trends in psychological theory*. Pittsburgh: University of Pittsburgh Press, 1951.
19. Rosenthal, D., & Frank, J. D. Psychotherapy and the placebo effect. *Psychol. Bull.*, 1956, 53:294-302.
20. Rosenzweig, S. Some implicit common factors in diverse methods of psychotherapy. *Amer. J. Orthopsychiat.*, 1936, 6:412-415.
21. Rosenzweig, S. A transvaluation of psychotherapy: a reply to Hans Eysenck. *J. abnorm. soc. Psychol.*, 1954, 49:298-304.
22. Salter, A. *Conditioned reflex therapy*. New York: Creative Age, 1949.
23. Shoben, E. J., Jr. Some observations on psychotherapy and the learning process. In O. H. Mowrer (Ed.), *Psychotherapy: theory and research*. New York: Ronald, 1953.

24. Wolstein, B. *Transference: its meaning and function in psychoanalytic therapy*. New York: Grune & Stratton, 1954.
25. Wyatt, F. The self-experience of the psychotherapist. *J. consult. Psychol.*, 1948, 12:82-87.
26. Ziskind, E. How specific is psychotherapy? *Amer. J. Psychiat.*, 1949, 106:285-291.

INDEXES

Index of Names

- Abel, Theodora M., 101, 103
 Adams, H., 17
 Adelson, J., 113, 132
 Agnew, J. W., Jr., 185, 188
 Albaugh, W. P., 229, 246
 Alber, Edna, 19
 Alexander, F., 113, 124, 133, 172, 186,
 193, 194-195, 203, 206, 211, 212,
 213, 215, 227, 280, 282, 284, 285,
 293
 Allport, G. W., 181, 187
 Alper, Thelma G., 17
 Anderson, H. H., 127, 133
 Anderson, S., 17
 Angel, E., x
 Appel, K. E., 275
 Arbuckle, D. S., 140, 156
 Aristotle, 92
 Arnhoff, F. N., 229, 247
 Ash, P., 221, 245
 Auld, F., Jr., 97, 103, 236-237, 238,
 242-243, 245
 Ausubel, D. P., 9, 11
 Azima, H., 88, 103

 Bailey, C., 223, 247
 Bakan, D., 291, 293
 Baker, Gertrude, 241, 247
 Balchin, N., 17
 Baldwin, A. L., 127, 133
 Bandura, A., 162, 187
 Barbara, D. A., 179, 187
 Barnett, H. G., 85, 103
 Barron, F., 239-240, 245
 Bass, B. M., 117, 133
 Bateson, G., 89, 108, 121-122, 128,
 130-131, 134, 167-168, 177, 188,
 281, 282, 286, 294
 Beaglehole, E., 84, 96, 103
 Beers, C., 17
 Belknap, I., 125, 133
 Bell, J. E., 200, 215
 Bellamann, H., 17
 Bellis, Elizabeth, 91, 95, 99, 102, 107
 Benedek, Therese, 210, 212, 215
 Benedict, Ruth, 83, 84, 85, 86, 103
 Berenda, C. W., 288, 293
 Bergum, Mildred, 56, 58, 75
 Berkeley, G., 142
 Berlioz, H., 226
 Berman, L., 209, 215
 Bidney, D., 80, 103
 Biestek, F. P., 72, 75
 Bindra, D., 187
 Bixler, R. H., 32, 40, 46, 51, 57, 58, 75
 Black, J. D., 98, 105, 295, 296, 299,
 301, 308
 Blake, R. R., 142, 157, 199, 215, 275,
 276, 277
 Bleuler, E., 221
 Boulding, K., 120
 Bordin, E. S., 5, 11, 31, 51, 172, 187,
 201, 202, 216, 221, 225, 226, 228,
 231, 245
 Bowman, K., 227
 Brain, W. R., 142, 157
 Brammer, L., 163-164, 189
 Brand, M., 17
 Brayfield, A. H., 218, 232, 245, 249, 294
 Breese, Fay, 127, 133
 Brewer, J., 127, 133
 Brody, B., 14, 27

- Brody, E. B., 9, 11, 162, 180, 187
 Brody, N. W., 218
 Bronfenbrenner, U., 258, 276
 Brown, C., 17
 Brown, Esther L., 125, 133
 Brown, R. W., 271, 276
 Bruner, J. S., 123, 133, 199, 216, 217, 255, 256, 258, 263, 276, 278, 292, 294
 Burgess, E. W., 78, 92, 103
 Butler, S., 17

 Caldwell, E., 17
 Carr, A. C., 244, 246
 Cartwright, D. S., 241-242, 243, 245, 296, 308
 Cartwright, Rosalind D., 241, 246
 See also Dymond, Rosalind
 Chein, I., 199, 217
 Christiansen, Carole, 238-239, 247
 Clark, R. E., 90, 91, 92, 103
 Clausen, J. A., 87, 88, 104, 106
 Cobb, S., 123, 227, 246, 304, 308
 Cohen, B. D., 271, 276
 Cohen, L. D., 229, 248
 Cohen, Mabel B., 208, 209, 210-211, 212, 216
 Coleman, J. V., 165, 187
 Collier, R. M., 295, 296-297, 308
 Combs, A. W., 139, 140, 142, 143, 144, 145, 147, 149, 158, 221, 246, 257, 259, 268, 270-271, 272, 274, 278, 283, 284, 294
 Conant, J. B., 139-140, 142, 157
 Conrad, J., 17
 Cooley, C. H., 78, 82, 104
 Cooper, J. M., 83, 87, 104
 Cooper, Marcia, 91, 108
 Cottle, W. C., 301, 309
 Cotton, J. W., 229, 247
 Cramer, Fern J., 88, 103
 Crane, S., 17
 Cromwell, N. A., 17
 Cronbach, L. J., 255, 276
 Crutchfield, R. S., 142, 157
 Cuadra, C. A., 229, 246
 Custance, J., 17
 Cutler, R. L., 120, 134

 Danskin, D. G., 99, 104
 Davenport, Beverly F., 229, 246
 Davidian, Elizabeth V., 164-165, 166, 187
 Davis, A., 83, 104
 Davis, K., 94, 104
 De Grazia, S., 59, 70, 73, 74, 75, 99, 104, 124, 133, 260-261, 276, 298-299, 300, 303, 309
 Dennis, W., 135, 276, 277, 309

 Deutsch, F., 65, 75, 124, 133, 181
 Devereaux, G., 84, 101-102, 104
 Diamond, B. L., 44, 51
 Dickson, W. J., 115, 126, 134
 Dobzhansky, T., 145, 157
 Dollard, J., 257, 270, 276
 Dos Passos, J., 17
 Dostoyevsky, F. M., 17
 Drolette, Margaret, 153, 156
 Dunham, H. W., 87, 88, 104
 Dymond, Rosalind F., 142, 151, 158, 171, 187, 244, 248, 309
 See also Cartwright, Rosalind D.

 Eaton, J. W., 84, 104
 Einstein, A., 141
 Eldred, S. H., 165, 166, 187
 Elizur, A., 240
 Elkin, F., 221, 229, 246
 Ellenberger, H. F., x, 228
 Ellis, R., 91, 92, 105
 Embree, R. B., Jr., 22, 27
 English, O. S., 284, 294
 Eron, L. D., 236, 237, 238, 245
 Estes, S. G., 201, 202, 203, 216, 301, 309
 Evans, Jean, 17
 Eysenck, H. J., 160, 161, 187, 296, 304, 305, 309

 Faris, E., 79, 82, 104
 Faris, R. E. L., 87, 88, 104
 Farrell, J. T., 17
 Faulkner, W., 17
 Ferenczi, S., 48, 192, 196, 213, 216, 298
 Fiedler, F. E., 172-173, 185, 187, 303, 309
 Filmer-Bennett, G., 242, 246
 Fisher, K. A., 280-281, 282, 283, 293
 Fisher, V., 17
 Flescher, J., 208, 216
 Fonda, C. P., 221-222, 249
 Forgy, E. W., 98, 105
 Frank, J. D., 225, 248, 303-304, 305-306, 309
 Freeman, Lucy, 17, 18
 French, T. M., 113, 124, 133, 190, 192, 194-195, 196, 197, 203, 206-207, 215, 280, 282, 284, 285, 293
 Frenkel-Brunswick, Else, 258, 276
 Freud, Anna, 258
 Freud, S., 10, 11, 123, 145, 160, 169, 191, 192, 193, 195, 198, 199, 200, 207, 213, 216, 227, 254, 257, 262, 276, 279-280, 285-286, 293, 294, 297, 298, 305
 Fricke, B., 246
 Fromm, E., 105
 Fromm-Reichmann, Frieda, 48, 49, 51,

- 122, 133, 157, 166, 168, 169, 186,
187, 189, 250, 268, 276
Frumkin, R. M., 90, 91, 105
Funkenstein, D. H., 153, 157
Fuson, W. M., 91, 105
- Galdston, I., 9, 12, 105, 275
Gallagher, J. J., 237, 240, 246
Galsworthy, J., 18
Garvel, Mary L., 108
Gellhorn, W., 114, 133
Gerber, I. J., 18
Ghiselli, E. E., 117, 133
Gibbs, W., 141
Gibby, R. G., 236, 237, 238, 246
Gibson, J. J., 262-267, 276
Gide, A., 18
Giedt, F. H., 182-183, 187, 241, 247
Gilbert, Doris C., 125, 133
Gillin, J., 18
Ginsburg, S. W., 53, 55, 59, 63, 65, 66,
75
Gitelson, M., 208, 209
Glover, E., 196, 216
Gluck, S., 32, 51
Goldhamer, H., 105
Goldman, L. L., 98, 108
Goldstein, K., 146, 157
Goldstein, N., 67, 69, 76
Goodman, Cecile G., 199, 216
Goodman, M., 231, 248
Goodstein, L. D., 98, 105
Gordon, T., 111, 114-115, 121, 123,
127, 133
Gough, H. G., 238, 240
Grayson, H. M., 229, 246
Green, A. W., 54, 57, 75
Green, J., 18
Greenacre, Phyllis, 49, 51, 194, 197,
200, 216
Greenblatt, M., 125, 133
Greenspoon, J., 68, 75, 271, 276
Grey, A. L., 14, 28
Grigg, A. E., 98, 105
Grummon, D. L., 309
Guertin, W. H., 223, 224, 247
Gutheil, E. A., xii
- Hackett, P., 18
Hahn, M. E., 31, 33, 40, 51, 179, 187
Hallowell, A. J., 83, 85, 87, 105, 142,
143, 157
Hammond, K. R., 237, 239, 248
Hand, H. C., 57, 75
Hardy, T., 18
Haring, D. G., 103, 104, 106, 107
Harris, R. E., 238-239, 247
Hartley, E. L., 133, 134
- Hathaway, S. R., 295, 296, 301, 304,
309
Havighurst, R. J., 83, 104
Headley, R. R., 231, 247
Hebb, D. O., 88, 105
Heimann, Paula, 207, 208, 209, 212,
216
Helfand, I., 144, 157
Henle, Mary, 139, 157
Herma, J. L., 53, 55, 66, 75
Hersko, M., 97-98, 108
Herzberg, A., 124, 133
Hildum, D. C., 271, 276
Hiler, E. W., 236, 237, 238, 246
Hilgard, E. A., 139, 142, 143, 147, 157
Hillyer, J., 18
Hippocrates, 220
Hoch, P., 186, 247, 249
Hoffer, W., 191-192, 197, 216
Hollingshead, A. B., 10, 12, 91, 92, 95,
96, 99, 102, 105, 107
Holt, R. R., 185, 188
Holzberg, J. D., 222, 224, 250
Honigmann, J. J., 80, 83, 85, 86, 105
Hora, T., 216
Horney, K., 86, 105, 149, 195, 196, 201,
206, 216
Horton, P., 18
Howard, A. R., 18
Hull, Helen, 18
Hunt, Edna B., 222, 247
Hunt, J. McV., 85, 105
Hunt, W. A., 220, 222, 226, 229, 234,
247
Husband, R. W., 18
Huxley, A., 18
- Ibsen, H., 18
Ifund, B., 67, 69, 76
Imber, S. D., 97, 106
Ingham, H. V., 65-66, 72-73, 75
Inkeles, A., 81-82, 106
Ivimey, Muriel, 216
- Jacks, I., 84, 86, 103
Jaco, E. G., 88, 106
Jahoda, Marie, 59-60, 76
James, W., 79
Janet, P., 144, 157
Jenkins, N., 199
Jenkins, R. L., 9, 12, 222, 247
Jessor, R., 142, 157
Johnson, Adelaide, 284, 294
Jones, M., 125, 133
Jonietz, Alice, 255-256
Joyce, J., 18
- Kalhorn, Joan, 127, 133
Kanzer, M., 195, 217

- Kaplan, B., 91-92, 106
 Kaplan, W. K., 271, 276
 Kardiner, A., 85-86, 106
 Katz, M. M., 238
 Kees, W., 144-155, 158, 179-180, 184, 188
 Kelly, G. A., 257, 276
 Kelman, H., 60, 61, 76, 225, 248
 King, Marian, 18
 King, S. H., 153, 157
 Kirby, E., 91, 92, 105
 Kirk, Barbara A., 231, 247
 Kirkner, F., 241, 247
 Klein, G. S., 256, 263, 276
 Klineberg, O., 81, 106
 Klopfer, B., 241, 247
 Kluckhohn, C., 54, 56, 76, 80, 83, 103, 104, 105, 106
 Knauss, Joanne, 237, 248
 Knight, J., 18
 Knight, R. P., 160, 188
 Kohler, W., 273
 Kohn, M. L., 87, 88, 104, 106
 Kotkov, B., 237, 247
 Kraepelin, E., 221
 Kramm, J., 18
 Krauch, E., 18
 Krech, D., 142, 157, 256, 275, 276
 Krim, Elaine, 181-182, 188
 Kroeber, A. L., 83, 106
 Krout, M. H., 9, 12, 27, 107
 Kubie, L. S., 227
 Lagache, D., 191, 192, 197, 217
 Lantz, H. R., 90, 91, 106
 Lawrence, D. H., 18
 Lawton, G., 51
 LeBar, F. M., 18
 Lecky, P., 146-147, 157
 Lee, A. McC., 76
 Leighton, A. H., 90, 106, 114, 134
 Lemkau, P., 91, 108
 Leonard, W. E., 18
 Levine, R., 199, 217
 Levinson, D. J., 125, 133
 Lewin, K., 127, 133, 257, 260, 276, 277
 Lewis, S., 18
 Lindesmith, A. R., 81, 106
 Lindner, R., 18, 59, 76
 Lindsley, O. R., 271, 277
 Linton, R., 79, 80-81, 83, 84, 106
 Lippitt, R., 127, 133, 134
 Little, Margaret, 208, 209, 212-213, 217
 Little, R. B., 41, 51
 Lorr, M., 222, 223, 236, 238, 244, 247, 249
 Louttit, C. M., 27
 Love, Leonore R., 65-66, 72-73, 75
 Luborsky, L. B., 185, 188
 Luft, J., 229, 247
 Macalpine, Ida, 190, 193-194, 195, 197, 204, 217
 McArthur, C. C., 232
 McClosky, H., 32, 34, 52, 56, 63, 76
 McConnell, J. V., 120, 134
 McCue, Miriam, 231, 248
 McCulloch, W. S., 261, 277
 McGinnies, E., 199, 217
 MacLean, M. S., 31, 33, 40, 51, 179, 187
 MacLeod, R. B., 142, 157, 291, 293
 McNeil, E. B., 120, 134
 Magaret, Ann, 270, 277
 Maier, N. R. F., 116, 126, 134, 199, 217, 262, 273, 277
 Maine, H., 18
 Mandler, G., 271, 277
 Mann, L., 94, 106
 Mann, T., 18
 Manoil, A., 183-184, 188
 Marshall, A. W., 105
 Maslow, A. H., 60-61, 76, 124, 134, 145-146, 147-148, 148-149, 150, 154, 156, 157, 162, 188
 May, R., x, 14
 Mayman, M., 228
 Mayo, E., 114, 115, 116, 123, 126, 134
 Mead, G. H., 78-79, 90, 106
 Mead, Margaret, 80, 83, 84, 93, 106, 107
 Meadow, A., 237, 247
 Meehl, P. E., 32, 34, 52, 56, 63, 76, 233-234, 248, 257, 267
 Mehlman, B., 221, 248
 Menninger, K., 12, 228
 Metzger, Emy A., 172, 188
 Miller, Christine, 236, 240, 242, 249
 Miller, D. R., 236, 237, 238, 246
 Miller, L. M., 27
 Miller, N. E., viii, 198, 217, 257, 271, 276
 Mindess, H., 241, 248
 Molnar, F., 18
 Money-Kyrle, R. E., 217
 Monroe, A. B., 224, 248
 Moony, R., 240
 Moore, W. L., 18
 Moreno, J. L., 122, 133, 157, 186, 189, 250
 Morrow, W. R., 185, 188
 Morse, Nancy C., 126-127, 134
 Mowrer, O. H., 5, 6, 7, 12, 19, 27, 62, 76, 83, 106, 128, 134, 198-199, 217, 278, 294, 309
 Muench, G. A., 244, 248
 Mullahy, P., 86, 90, 104, 107, 217

- Murphy, G., xii, 54, 69, 70, 71, 76, 82, 107, 199, 217, 218, 257, 262, 277
 Murphy, Lois B., 54, 76, 262, 277
 Murphy, W. F., 65, 75, 124, 133
 Murray, H. A., 103, 104, 105, 106
 Myers, J. K., 91, 96, 97, 98, 107, 108, 236-237, 242-243, 245

 Nacht, S., 195, 217
 Nash, E. H., Jr., 97, 106
 Neuman, H., 227-228, 229
 Newcomb, T. M., 54, 76, 133, 134, 142, 146, 157, 262, 277
 Newman, E. B., 58, 76
 Nolan, W. J., 90, 107
 Nunberg, H., 191, 197, 199-200, 217

 Oberndorf, C. P., 9, 12, 268, 277, 297, 309
 O'Connor, J. P., 222, 247
 O'Neill, E., 18
 Opler, M. K., 82, 84, 86, 87, 92, 101, 107
 Oppenheimer, O., 300, 309
 Orr, D. W., 208, 217
 Orwell, G., 121, 132, 134, 150, 157, 171, 188

 Packard, V., 119, 120-121, 134
 Parloff, M. B., 65, 66-67, 68, 69, 76, 185, 188, 225, 248
 Patterson, C. H., 6, 8, 12, 19, 28, 98, 107, 157, 170, 188, 246
 Pattison, H. A., 249
 Paulsen, Lola, 200, 217
 Pearse, I. H., 127, 134
 Peiffer, H. C., 77
 Penfield, W., 261, 277
 Pepinsky, H. B., viii, 14, 28, 232, 248, 283-284, 287, 288, 289, 290, 294
 Pepinsky, Pauline N., viii, 14, 28, 248, 283-284, 287, 288, 289, 290, 294
 Perlman, Helen, 286-287, 294
 Perry, Helen S., 108
 Perry, W. G., Jr., 8, 12
 Phillips, E. L., 185, 188, 255, 257, 258, 259, 260, 267, 277
 Plant, J., 81, 86, 107
 Porter, E. H., Jr., 7, 12
 Postman, L., 199, 217, 256, 277
 Proshansky, H., 199, 217
 Pruyser, P., 228

 Racker, H., 48, 207, 208, 209, 212, 217
 Rado, S., 192
 Raimy, V. C., 13, 28
 Ramsey, G. V., 142, 157, 199, 215, 275, 276, 277
 Rank, O., 196, 216

 Rawlings, M. K., 18
 Redlich, F. C., 10, 12, 91, 92, 95, 96, 97, 99, 102, 105, 107, 187, 227, 248
 Reed, R. B., 91-92, 106
 Reich, Annie, 209, 217
 Reich, W., 181
 Reik, T., 170-171, 188, 280, 294
 Reimer, E., 126-127, 134
 Richards, J., 126
 Richardson, W., 91-92, 106
 Rioch, D. McK., 296, 309
 Rioch, Janet MacK., 195, 204, 217
 Roberts, B. H., 107
 Roberts, L. K., 239, 248
 Robinson, H. A., 91, 96, 97, 107
 Robinson, J. T., 229, 248
 Roethlisberger, F. J., 115, 126, 134
 Rogers, L. S., 237, 239, 248
 Rogers, C. R., ix, xii, 15, 19, 22, 23-24, 25, 28, 57, 61, 73, 76, 95, 107, 121, 123, 127, 130, 132, 134, 139, 142, 146, 150, 151, 154-155, 156, 157, 158, 162, 167, 170, 171-172, 174-175, 176, 185, 186, 188, 203, 204, 205, 214-215, 217, 230, 231, 233, 244, 248, 255, 268, 271, 272, 277, 281, 289, 290-292, 294, 309
 Rolvaag, O. E., 18
 Rose, A., 90, 91, 104, 105, 107, 108
 Rosenberg, S., 240-241, 249
 Rosenthal, D., 67, 69, 77, 303-304, 305-306, 309
 Rosenthal, M., 231, 248
 Rosenzweig, S., 160, 188, 295, 296, 305, 309
 Rubinstein, E. A., 222, 223, 236, 238, 247, 249
 Ruesch, J., 89, 94, 108, 113, 129, 134, 144, 145, 158, 177, 179-180, 184, 188

 Salter, A., 124, 134, 302, 309
 Sanderson, H., 6, 12, 165, 166, 189
 Sanford, F. H., 9, 12
 Sanford, R. N., 199, 218
 Santayana, G., 18
 Sarbin, T. R., 228, 249
 Sargent, Helen, 31, 52, 77
 Sargent, S. S., 103, 106, 107
 Sargent, W., 120, 134
 Saslow, G., 123, 134
 Schaffer, L., 97, 98, 107, 108
 Schilder, P., 87, 108, 181
 Schimideberg, Melitta, 194, 200, 218
 Schmidt, H. O., 221-222, 249
 Schnitzler, A., 18
 Schwartz, M. S., 125, 135
 Schwebel, M., 35-36, 44, 47, 50, 52
 Scott, W. A., 59, 77, 92, 108

- Seabrook, W., 18
 Secheyay, Marguerite, 180, 189
 Seeley, J. R., 77
 Seeman, J., 32, 40, 46, 51, 57, 58, 75, 176, 189, 242, 249
 Selye, H., 151-152, 153, 158
 Seward, Georgene H., 82, 87, 93, 99-100, 108
 Sewell, L. G., 18
 Shafer, R., 199, 218
 Shartle, C. L., 117-118, 135
 Shaw, F. J., 270, 277, 278
 Shoben, E. J., Jr., viii, 44, 52, 62, 77, 270, 273, 278, 284, 294
 Shostrom, E. L., 163-164, 189
 Shrodes, Caroline, 18
 Simon, B., 224, 247
 Sinick, D., 164, 189
 Skaggs, E. B., 151, 158
 Skinner, B. F., 121, 128-130, 131, 132, 135, 267, 278
 Slotkin, J. S., 100-101, 108
 Smelser, W., 236, 240, 242, 249
 Smith, Marion W., 103, 106, 107
 Smith, M. B., 55, 59-60, 77, 157, 255, 256, 258, 278, 292, 294
 Snyder, W. U., 160, 176, 189
 Snugg, D., 139, 140, 142, 143, 144, 145, 147, 149, 158, 232, 249, 257, 259, 274, 278, 283, 284
 Sonne, T. R., 98, 108
 Spiro, M. E., 82, 108
 Spitz, R. A., 194, 218
 Stafford, J. W., 222, 247
 Stainbrook, E., 227, 249
 Stanton, A. H., 125, 135, 148, 158, 227, 249
 Steffins, L., 19
 Steinbeck, J., 19
 Stone, A. R., 97, 106
 Stotsky, B. A., 95, 108, 236, 237, 238, 246
 Strauss, A. L., 81, 106
 Strecker, E. A., 41, 51, 226, 249
 Strupp, H. H., 174, 176, 184, 189, 286, 294
 Stub, H., 91, 108
 Sullivan, H. S., 8, 49, 52, 61, 77, 86, 89, 108, 172, 189, 260, 268
 Sullivan, P. L., 236, 240, 242, 249
 Super, D. E., 5, 12
 Sutich, A., 31, 52, 56, 58, 77, 122, 135
 Symonds, P. M., 136-137, 139, 158, 163
 Szasz, T. S., 52, 221, 249
 Taulbee, E. S., 238, 249
 Taylor, Charlotte P., 68, 77
 Taylor, Janet A., 237, 240
 Taylor, J. W., 243, 249
 Thomas, L. G., 116, 135
 Thomas, W. I., 78
 Thompson, Clara, 195, 197, 213, 218
 Thorne, F. C., 41, 42, 52, 69, 77, 138, 139, 158, 225, 228-229, 231, 244, 249
 Tietz, C., 91, 108
 Titchener, E. B., 266
 Tolman, E. C., 293
 Tolman, Ruth S., 229, 246
 Tolstoy, L., 19
 Treudley, Mary B., 95, 108
 Tudor, Gwen E., 180, 189
 Turgenyev, I., 19
 Tyler, Leona, 164, 189
 Undset, Sigrid, 19
 Van Gundy, J., 18
 Vernon, P. E., 181, 187
 Verplanck, W. S., 68, 77, 271, 278
 Waelder, R., 194, 218
 Walker, D. E., 77, 123, 135
 Ward, Mary, 19
 Warkentin, J., 213-214, 218
 Warnath, C. F., 37, 52
 Warner, W. L., 85, 108
 Wartens, Jane, 4, 12
 Watson, J. B., 129
 Weigert, Edith, 212, 213, 218
 Weihofen, H., 44, 51
 Weill, R. J., 84, 104
 Weinberg, S. K., 84, 86, 87, 89, 108, 113, 135
 Weiss, F., 65, 77
 Weiss, W., 223, 247
 Weisskopf-Joelson, Edith, 69, 77
 Weitz, H., 51, 52
 White, R. K., 127, 133, 134
 White, R. W., 19, 148, 158, 255, 256, 258, 278, 292, 294
 Whyte, W. H., Jr., 117, 135, 256, 278
 Wiener, N., 141-142, 144, 158
 Wilder, J., 53, 65, 68
 Williams, G. S., 127, 134
 Williams, R. M., 54
 Williamson, E. G., 71, 77, 137, 138, 139, 140, 158, 164, 189, 228, 249
 Wilson, W. C., 271, 278
 Winder, A., 97-98, 108
 Windle, C., 242, 250
 Wisham, W., 241, 247
 Wittenborn, J. R., 222, 223, 224, 244, 249, 250
 Wittson, C. L., 222, 247
 Wolberg, L. R., 66
 Wolfe, T., 19

- Wolff, W., 181, 189
Wolstein, B., 218, 281, 282, 287, 294,
297, 310
Wood, A. B., 218
Woodson, Marion M., 19
Woodworth, R. S., 183, 189
Wrenn, C. G., xii, 3, 12, 21, 28, 32, 40,
41, 43, 44, 48, 51, 52, 69, 77
Wright, R., 19
Wunsch, R. V. R., 19
Wyatt, F., 49, 52, 160-161, 189, 204,
218, 233, 250, 267, 278, 301, 310
York, R. H., 125, 133
Zetzel, Elizabeth R., 195, 200, 218
Zilboorg, G., 54, 77, 168, 170, 189,
226, 227, 229-230, 250
Ziskind, E., 295, 296, 298, 299, 303, 310
Zubin, J., 247, 249

Index of Subjects

-
- Acceptance, 149
 Adjustment as goal of therapy, 59, 60, 62
 Allport-Vernon-Lindzey Scale of Values, 67
 American Association for Applied Psychology, Subcommittee on Graduate Internship Training, 14
 American Personnel and Guidance Association, 22
 American Psychoanalytic Association, 284
 American Psychological Association, 21, 22
 code of ethics, 31 ff.
 Committee on Training in Clinical Psychology, 13
 Division of Counseling Psychology, Committee on Counselor Training, 14
 Division of Counseling Psychology, Committee on Definition, 4
 Education and Training Board, Committee on Subdoctoral Education, 14
 Subcommittee on Graduate Internship Training, 14
 Ann Arbor Conference, 4
 Anxiety in therapist, 160, 161, 162
 Authority in therapy, 99
 and placebo effect, 304
 and transference, 204
 as common element, 298-300
 Barron Ego Strength Scale, 240
 Behaviorism, 256
 Bender-Gestalt Test, 224
 Client-centered therapy, vii, viii-ix
 advantages of, 141
 nature of, 140-156
 Cognitive adequacy as goal of therapy, 59-60, 62
 Communication, and countertransference, 210, 215
 and development of self-concept, 144-145
 and role taking, 89-90
 defects in, and emotional disturbances, 88, 89, 92-93
 of understanding, 174-179
 nonverbal, 179-184
 Confidentiality of information, 43-46
 Continuation in therapy, prediction of, 236-238
 Control, problem of, 128-132
 Counseling, and psychotherapy, x, 3 ff.
 educational, 5-6, 7
 focus of, 6, 8
 marital, 5-6
 personal, x, 6-7, 8
 techniques, 7
 therapeutic, x, 7, 11
 vocational, 5-6, 7
 See also Psychotherapy
 Counseling psychology, 4-5
 Countertransference, 207-215
 definition of, 208
 handling of, 211-215
 recognition of, 209-210
 Cultural isolation theory of emotional disturbances, 88-89
 Culture, and attitudes toward therapy, 94-96
 and client expectations, 98-99
 and communication in therapy, 102
 and emotional disturbance, 83-93
 and personality, 78-83
 and psychoanalysis, 101-102
 and techniques of therapy, 99-103
 change and emotional disturbance, 85
 complexity and emotional conflict, 82-83
 conflict and emotional disturbance, 84, 86

- Depth psychology, x, 254-258
- Diagnosis in therapy, 219-230
 - as understanding, 228-230
 - nature of, 219-222
 - relation to therapy, 225-226
 - studies of, 222-224
- Eclecticism, 136-140
- Ecology of emotional disturbances, 87
- Ego psychology, 258
- Electroencephalogram, 235
- Emotional disturbance and cultural factors, 83-93
- Empathy, 171-172
- Environmental manipulation, 102
- Ethics of counseling and psychotherapy, 31-51
 - and needs of therapist, 46-51
 - and values, 58
- Ethnocentrism Scale, 240
- Existentialism, x
- Evaluation and therapy, 234-243
- Expectations of therapist, 159-162
- F-Scale, 238
- Free will, 129, 130
- General Adaptation Syndrome, 151-152
- Gestalt psychology, 257
- Goals of counseling and psychotherapy, 33
 - and techniques, 34
 - and values, 58-64
 - conflict between client and therapist, 62
- Gough Intellectual Efficiency Scale, 240
- Gough Social Status Scale, 240
- Group therapy, 102
- Guidance, 3
- Hawthorne experiment, 115-116, 126
- Hospital Adjustment Scale, 223
- Independence as goal of therapy, 61
- Information giving, x, 7, 8
- Integration as goal of therapy, 59
- Interference theory, 257
- Interpretation as fostering dependency, 206
- Isolation and emotional disturbances, 88, 92
- Learning and psychotherapy, 270-273
- Limitations of therapist, recognition of, 35
- Listening as basic technique, 168-170
- Manipulation, as approach to human relations, 111-132
 - as reflection of scientific point of view, 113, 282
 - in psychotherapy, 282-284, 289-290
- Mental health, concepts of, 59-64
- Mentally ill, institutional care of, 124-125
- Minnesota Multiphasic Personality Inventory, 238, 239, 240
- Motivation, 236
- Motivation research, 119
 - ethical problems in, 120-121
- Needs of therapist in psychotherapy, 46-51
- New York Academy of Sciences, Commission in Counseling and Guidance, 8
- Nonverbal communication, 179-184
- Occupation and emotional disturbance, 90-91
- Operant conditioning, 68, 271-272
- Organic treatment, 102
- Perception, 259-267
- Personal therapy in training for psychotherapy, 20
- Personality of therapist, 14-15, 19-20, 46-51
- Phenomenology, vii, ix, 26, 141, 259-270
- Philosophy, client-centered, ix, 57-58, 74-75
 - of life and therapy, 69-71
- Placebo effect, 303-308
 - and authority, 303, 306
 - and interest, 303, 306
- Play therapy, 102
- Practicum training, xi, 21-23
 - as test of therapeutic personality, 15
 - goals of, 22
 - theory in, 22-23
- Privileged communication, 43
- Projective techniques, 255
- Psycho-osmosis, 81
- Psychoanalysis, viii
 - and client-centered therapy, 141
 - and culture, 101-102
 - and transference, 190-207
- Psychological literature, reading list, 17-19
- Psychology of personal constructs, 257
- Psychotherapy, and counseling, x, 3 ff.
 - and therapist's personality, 14-15, 19-20, 46-51, 185-186
 - art or science, 279-293
 - as learning, 270-273
 - background for, 13-19

- Psychotherapy—*Continued*
 common elements in, 295–308
 conditions of, 153–156
 definition, 13
 limitations of, 159–162
 practicum training, 21–23
 training techniques, 20–21
 who should engage in, 9–11
- Responsibilities of counselor and psycho-
 therapist, conflicts of, 42–43
 to client, 32–36
 to client's family and relatives, 36–37
 to employer, 37–38
 to himself, 41–42
 to profession, 34, 39
 to referral sources, 38–39
 to society, 39–41
- Responsibility, 62
 Responsible independence, 62
 Role taking, and communication, 89–
 90
 and development of self, 144–145
 and empathy, 171–172
 Rorschach Test, 237, 238, 239, 240
 Rorschach Prognostic Rating Scale, 241
- Security of therapist, 49, 162
 Selection of clients, 234–243
 Selection of psychotherapists, 19–21
 Self, as a social product, 78 ff., 142–143
 primacy of, 142–143
 Self-actualization, 59, 60, 61, 62, 145,
 146
 Self-concept, and therapy, 149
 as basis of motivation, 145–146
 development of, 144–145
 threat to, and emotional disturbance,
 147–148
- Self-esteem, 62, 63, 89, 90, 93, 94, 149
 loss of, in emotional disturbance, 148
 Self-theory, viii
 Social class, and attitudes toward
 therapy, 95–96
 and client expectations, 98–99
 and duration of therapy, 97
 and treatment methods, 96–98
 and types of emotional disturbance,
 91–92
 See also Culture
 Social drift theory of emotional disturb-
 ances, 92
 Spontaneity of therapist, 213–215
 Spontaneous remission, 296
 Stress, 151–153
 Student personnel work, 3–4
 Subliminal stimulation, 119–120
- Success of psychotherapy, prediction of,
 238–244
- Taylor Manifest Anxiety Scale, 237, 240
 Techniques, 166–179
 and attitudes, 166–168, 185
 and goals of counseling and psycho-
 therapy, 34
 and therapist's personality, 184–185
 Tests in therapy, 230–233
 Thematic Apperception Test, 232
 Therapeutic counseling, x, 7, 11
 See also Psychotherapy
 Threat, and restriction of perception,
 262
 and transference, 204
 as source of emotional disturbance,
 147–148
 to self-concept, 147
 Training of psychotherapists, 13–27
 Transference, 190–207
 and ambiguity, 201–202
 and generalization, 197–199
 and perception, 199–203
 and projection, 199–203
 and rapport, 190
 as adaptation to psychoanalytic situa-
 tion, 193–194
 definitions of, 191–193
 in brief analytic therapy, 194–195
 in client-centered therapy, 203–207
 in neo-analysis, 195–196
- Unconscious, 254, 257, 260–261, 269
 Understanding, 170–174
 and diagnosis, 228–230
 and empathy, 171–172
 as approach to human relations, 111–
 132
 as basic requirement of therapy, 16,
 103, 149–150
 as common element in therapy, 300–
 303
 communication of, 174–179
 development of through reading, 16–
 19
 Values in therapy, 53–75
 and ethics, 58
 and goals, 58–64
 and methods and techniques, 64–65
 and philosophy, 56–58
 definitions of, 54–56
 imposition of, on client, 69–75
 Vocational counseling, 5–6, 7
- Wechsler-Bellevue Intelligence Scale,
 239, 240

UNIVERSAL
LIBRARY



124 211

UNIVERSAL
LIBRARY